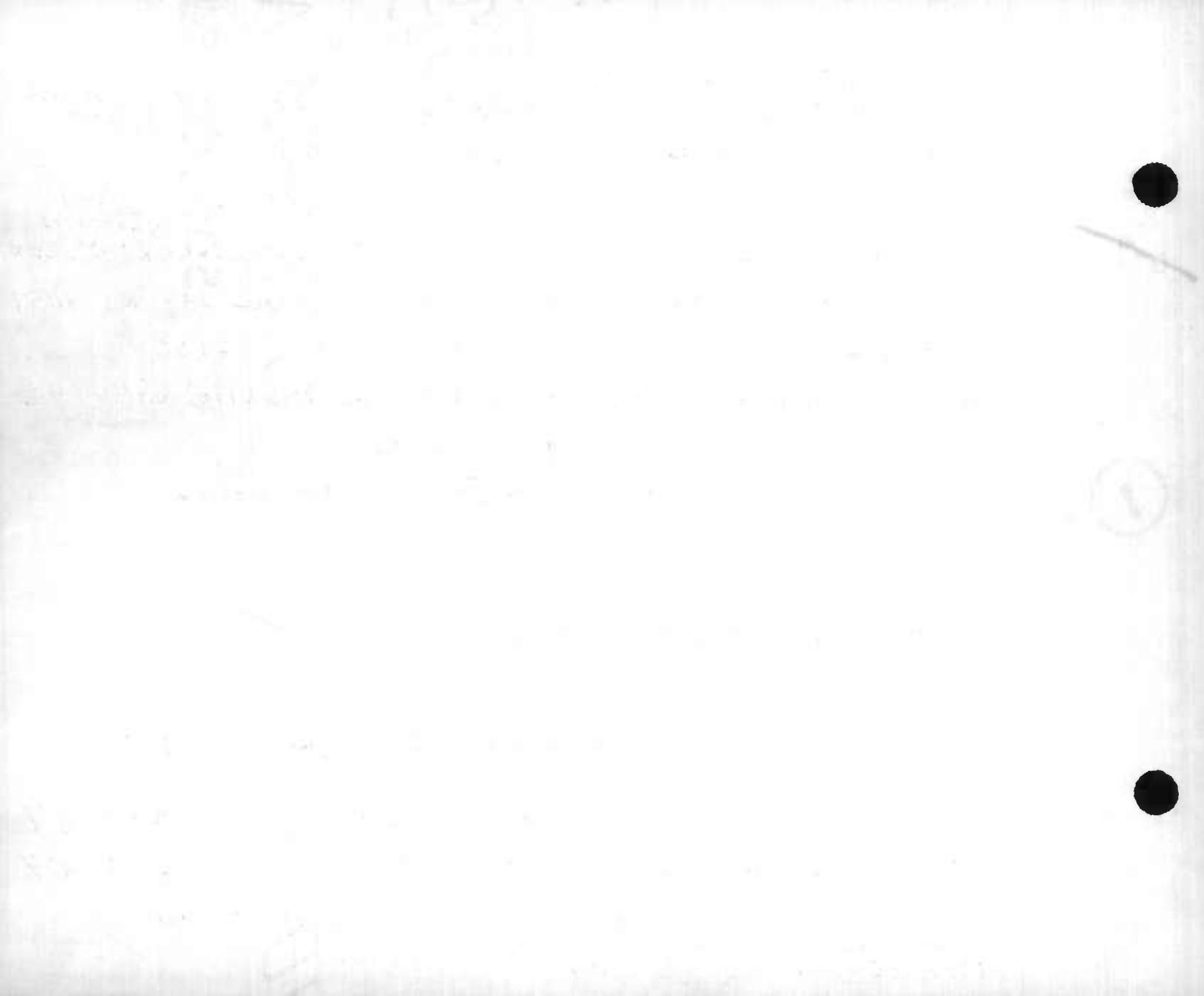


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TD FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 thru 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 there is only injury, or other traumatic event, the medical number must be placed on line

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												87	04393			
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			ELMER L. ALBAN (LAST)			2d DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR				
ELMER			L. ALBAN			2-10-87						7:30 P.M.				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE			CAUC			MONTH DAY YEAR			67			MONTHS DAYS		HOURS MIN.		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
MD			USA						CARROLL COUNTY MD.			OFFICER CLERK GRAIN ELEV.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			12b. KIND OF BUSINESS OR INDUSTRY				
WEST MINSTER			152 SULLIVAN RD			YES			152 SULLIVAN RD 21657							
13b. STATE			13c. COUNTY CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			12c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
MD			BARROLL WESTMINSTER			YES										
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
SAMUEL L. ALBAN			FRANCES R. LISSY			217-26-9018			AUDREY ALBAN (wife) SAME ADD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pancreatic carcinoma</u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
12-87			carcarea			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from Dec 87 to Jan 87, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE												DEGREE				
William J. Macon MD												ATTENDING PHYSICIAN DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>				
22c. DATE SIGNED			2-11-87													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL HOME, INC.			23d. LOCATION CITY OR TOWN COUNTY STATE	
WILLIAM MACON, MD			7620 York Rd, Towson, Md 21204			BURIAL 2-14-87			2-14-87			PARKWOOD CEM. HOME, INC.			BALTO, MD	
24. FUNERAL DIRECTOR FUNERAL NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
SCARFUNKER			9705 BELAIR RD			FEB 13 1987										
			21236													



044500 FEB 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8704874
REG. NO.

FOR STATE REGISTRAR		FIRST AIRY		MIDDLE V.	LAST BISH	2a. DATE OF DEATH 2-4 1987	MONTH 2	DAY 4	YEAR 1987	2b. HOUR M	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 11 DAY 12 YEAR 1887		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	2d. HOUR HOURS 0	MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL					
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 30 KEMPER AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME					
13a. STATE MD.		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 30 KEMPER AVE 21157				
14. FATHER'S NAME FIRST AB RAHAM		MIDDLE FRANK	LAST CROUSE	15. MOTHER'S MAIDEN NAME FIRST ELIZABETH		MIDDLE SHAR RER	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT CARROLL BISH		ADDRESS 13e 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCVD 2 years											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Colon Cancer, Metastatic											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (s) this hospital attended the deceased from 1/18 1987 to 1/23 1987, that (s) we lost saw the deceased alive on 1/27 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (we) did (did not) view the body after death.											
22b. SIGNATURE Norman Goldstein		22c. DEGREE and		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 2/6/87					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Norman Goldstein, M.D.		22f. ADDRESS 218 Wash. Hts. Med. Ctr., Westminster, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/7/87		23c. NAME OF CEMETERY OR CREMATORIAL Kriders		23d. LOCATION CITY OR TOWN Westminster		COUNTY Carroll	STATE Md.		
24. FUNERAL DIRECTOR NAME Robert Kyb Brumba		ADDRESS Westminster, Md		25a. DATE RECEIVED BY REGISTRY FEB 13 1987		25b. REGISTERED BY SIGNATURE Julia Johnson					

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached from the burial permit form and sent to the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked as having been caused by an injury, air or other traumatic event, the medical certificate must be signed by the hospital or attending physician.

3

046474

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 04893

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
JOHN			Samuel	BRICKER		2 27 87				6 30 A.M.	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
MALE		CAUCASIAN	MONTH	DAY	YEAR	76	YEARS	MONTHS	DAYS	8. IF UNDER 24 HRS	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA						CARRALL COUNTY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
WESTMINSTER		933 WESTERN CHAPEL ROAD			Chemist			Rubber			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS / ZIP CODE					
MARYLAND		13b. STATE CARROLL		13c. CITY OR TOWN TANEYTOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4358 STUMPTOWN Rd. 21787			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
William		F.		Bricker		Bernice				Bower	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT KITTY WARNER		ADDRESS 933 WESTERN CHAPEL Rd. Westminster, MD 21157		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS			
No		216-05-0884									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ALZHEIMERS DISEASE											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (A) HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (1) (this hospital) attended the deceased from 3/19 1977 to 2/27 1987, that (1) (we) last saw the deceased alive on 1/13 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE			22d. DATE SIGNED						
<i>John R. Linticum, M.D.</i>					2/27/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
John R. LINTICUM, M.D.		TANEYTOWN, MD 21787									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		23e. COUNTY			STATE
Burial		3/2/87		Trinity Lutheran		Taneytown, Carroll, Maryland					
24. FUNERAL DIRECTOR NAME		136 E. Baltimore St. Taneytown, MD 21787			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Skiles Funeral Home					MAR 03 1987		<i>Marion Pendleton</i>				
DHMH - 16 50M 4/83 (VRA 15, 4)											

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100 80 90 V

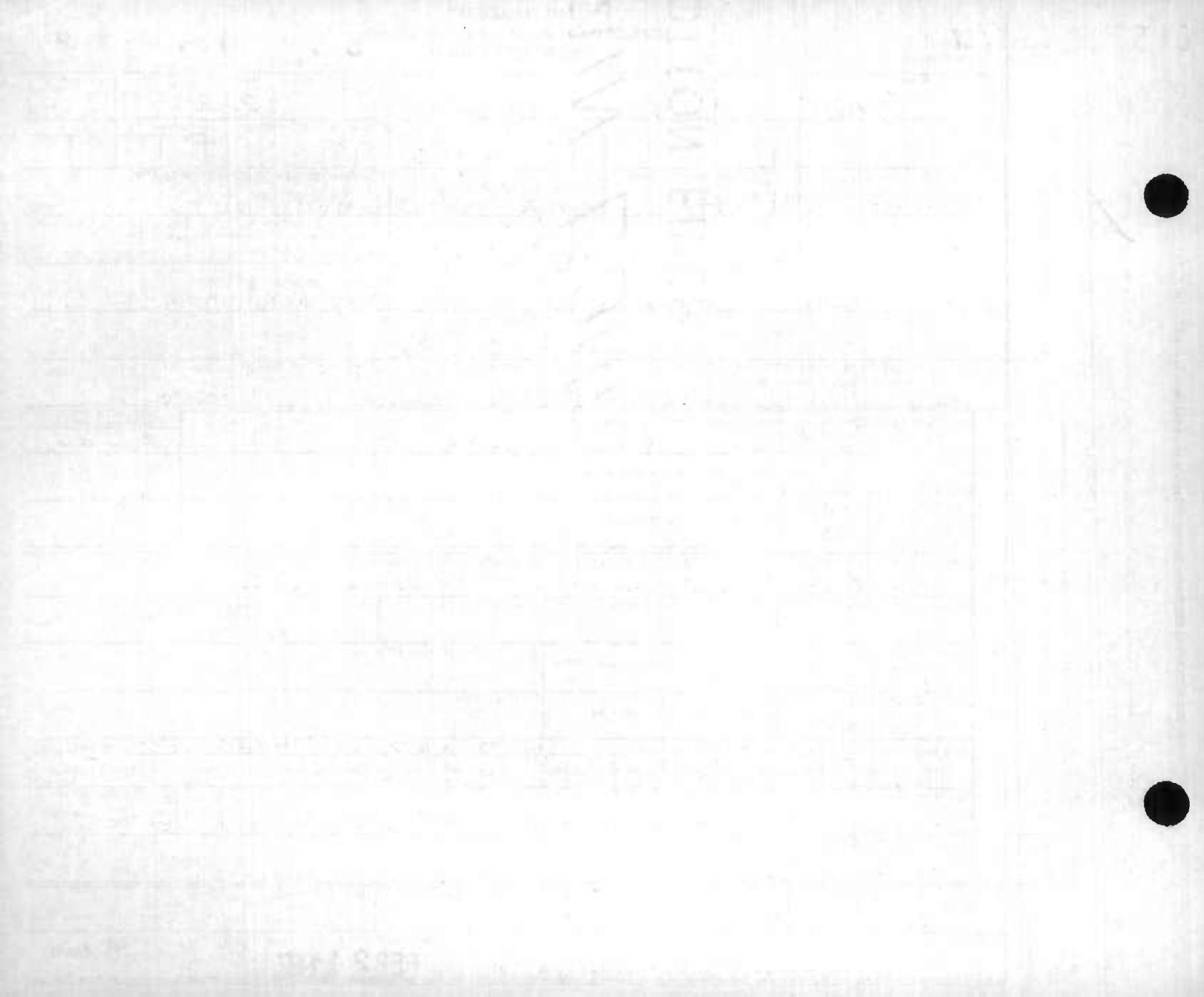
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8704890											REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR
Samuel				Carson	Brooks	2b. DATE OF DEATH			2	20	87
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
M			B			MONTH 10 DAY 10 YEAR 1893			IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			U.S.A.						Carroll County MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminster			Carroll County General Hosp.			boiler attendant			cement co.		
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MD			Carroll			Union Bridge			Box 68 McKinstry Mill Rd. 21791		
14. FATHER'S NAME FIRST			LAST			15. MOTHER'S MAIDEN NAME			LAST		
George			Brooks			Gertrude			Thomas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			W W I			Leroy Brooks			1024 McKinstry Mill Rd. Union Bridge, MD		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b and c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Hemocultestinal bleeding</u> <u>Rectal polyp</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>2/17/87</u> , to <u>2/20/87</u> , that (I) (we) last saw the deceased alive on <u>2/20/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Vincent J. Fiocco</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2/20/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
Vincent J. Fiocco			8 Anchor St. Westminster, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		
Burial			2/25/87			Mt. Joy Cemetery			Carroll		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
D. D. Hartzler			Union Bridge, MD			FEB 24 1987			<u>Julia Gordon-Landau</u>		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8704891

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST			2. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
MARIAN Reifsneider BUSHEY			2-10-87	0058 M	
3. SEX F	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS LAST BIRTHDAY	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
		12-30-06	80	1 10	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.		
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5122 Bushey Rd., 21784	
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
David B. Reifsneider	Elizabeth		Null		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. 217-46-1083	17. INFORMANT James L. Bushey, Jr., Same as # 13	ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS		
DUE TO, OR AS A CONSEQUENCE OF (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a CEREBRO VASCULAR ACCIDENT					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from FEB 9 1987 to FEB 10 1987, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE ARTHUR L. RUDO, M.D.	DEGREE		22c. DATE SIGNED 2/10/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR L. RUDO, M.D.	22e. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER, MARYLAND 21157				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-13-1987	23c. NAME OF CEMETERY OR CREMATORIUM Lakeview Memorial	23d. LOCATION CITY OR TOWN Eldersburg, Md.	23e. COUNTY Carroll, Md.	23f. STATE
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.	25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR 25d. REGISTRAR'S SIGNATURE		
DHMH - 16 60M 7/84 (VRA 15, 4)					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed for use on the burial permit. Then phone or write to the State Dept. of Health and Mental Hygiene prior to burial, removal, or cremation.

IMPORTANT: If item 21 is marked or item 19 shows any injury or other significant event, the medical examiner must be informed.

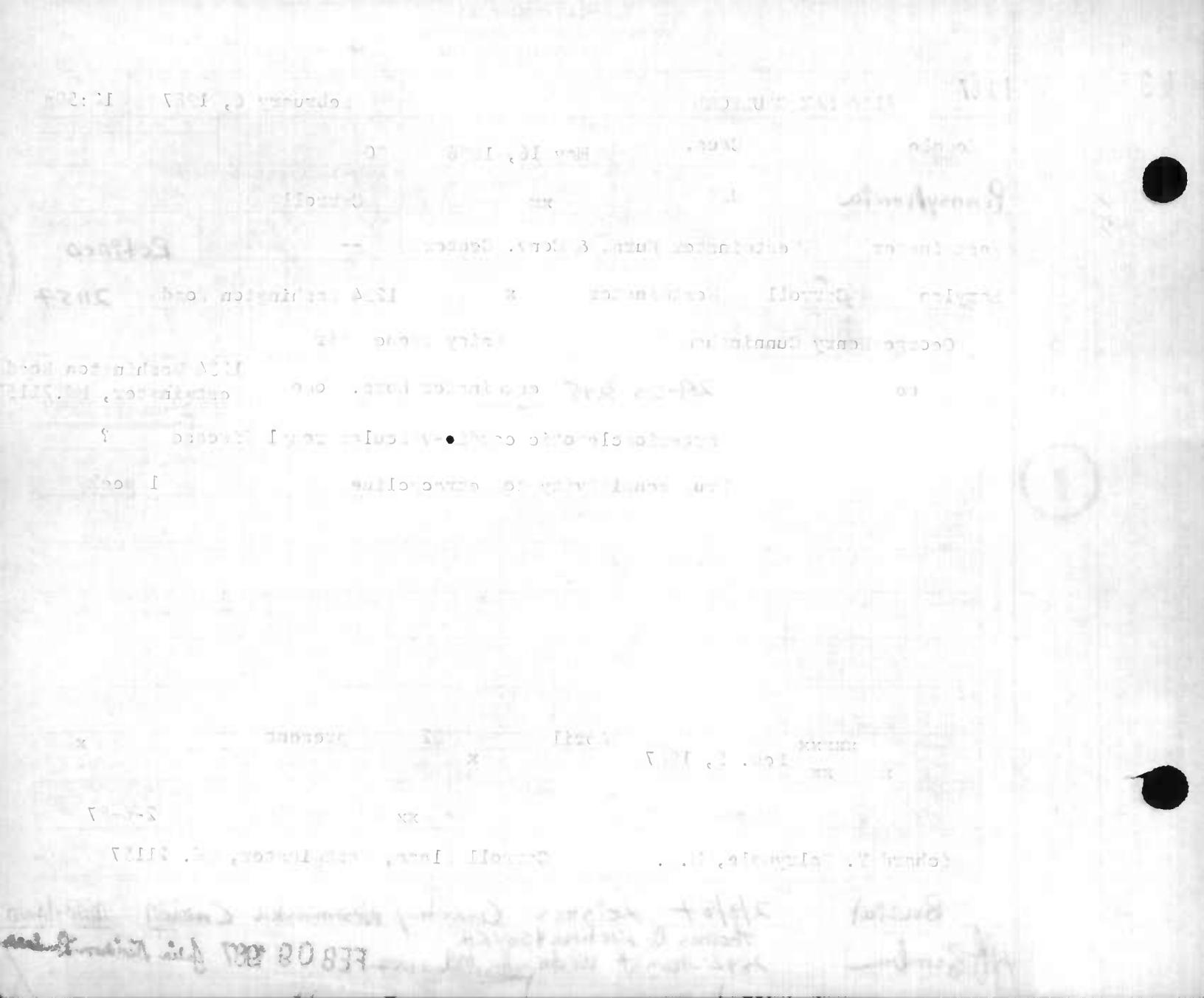
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8704898

1. RELEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
ALDA MAY CAULFORD						February 6, 1987				12:50a	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female		Caus.		MONTH DAY YEAR May 16, 1896		90		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Westminster Nurs. & Conv. Center						--		Retired	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Carroll		Westminster		YES <input checked="" type="checkbox"/>		1234 Washington Road		21157	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
George Henry Cunningham					Daisy Irene Bair						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no		29-03-3645		Westminster Nurs. Home		1234 Washington Road					
Westminster, Md. 21157											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardio-vascular renal disease ? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) Drug sensitivity to Tetracycline 1 week											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (XXXXXX) attended the deceased from April 19, 1982, to present, 19 , that (I) (X) last saw the deceased alive on Feb. 5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (X) (did) (d) (X) view the body after death.											
22b. SIGNATURE <i>Richard Y. Dalrymple, M.D.</i>		DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-6-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Richard Y. Dalrymple, M.D.		Carroll Plaza, Westminster, Md. 21157									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/8/87		23c. NAME OF CEMETERY OR CREMATORIAL Leisters Cemetery		23d. LOCATION CITY OR TOWN Westminster		COUNTY Carroll		STATE Maryland	
24. FUNERAL DIRECTOR H. Zumbro		25a. DATE REC'D. BY REGISTRAR 254 E. Main St. Westminster, Md. 21157 FEB 09 1987		25b. REGISTRAR'S SIGNATURE Julia Dandrea-Redden							
ADRESSES											

BP _____
DHMH - 16 60M 7/84
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition. Pages 1 & 2 should be filed with the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition, mark the corresponding column in Part 1.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8704847					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
Edmund Pendleton			Cohill, II.			Feb 28, 1987			12 ⁰⁵ AM						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
Male		White		May 17, 1912			74 YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH					
Maryland		United States					Carroll, MD.			Mt. Airy					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				13a. STREET ADDRESS / ZIP CODE				
Pleasant View Nursing Home				Orchardist			Agriculture				4101 Baltimore Nat. Pike 21771				
13a. STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.				17. INFORMANT				
James Andrew Cohill, Sr.				Helen Morgan			065-42-2634M				Roger Cohill P.O. BOX 488 Boykins, Virginia 23827				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF 1b) cardiac arrhythmia Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF 1c) a atherosclerotic heart disease yrs Approximate interval between onset and death min															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Diabetes, emphysema, Arthritis, Schizophrenia, hypertension															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from 6/22, 1977, to 2/28, 1987, that (1) (we) last saw the deceased alive on 2/26, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2/28/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
Melvin J. Gordon			2000 Century Plaza			Colmar Blvd Hancock, Maryland 21750									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Burial			3/2/1987			St. Peters Catholic			Hancock, Washington, Md. 21750			MAR 10 1987		Julia Scidmore-Lundae	
24. FUNERAL DIRECTOR NAME _____ ADDRESS _____															
Tulane DeLoach			Hancock MD												
DHMH - 16 60M 7/84 (VRA 15, 4)															

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Vol. 0-0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please file pages 1 and 2 with 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event the medical examiner must be called at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Joseph Leo CONCANNON						FEB. 17, 87				1339 M	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male	White		MONTH	DAY	YEAR	68	YRS	MONTHS	DAYS	IF UNDER 24 HRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH						
Balto. County		USA			Carroll			MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Westminster Carroll County Gen. Hosp.					Retired			Truck Driver			
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md		Balt		Reisterstown		YES <input type="checkbox"/> NO <input type="checkbox"/>		13018 Old Hanover Rd 21136			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS				
Edward				Concannon	Mary		M. Wilhelm				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO.			17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes WW II		219-16-3746			Mrs. Ruth Concannon 13018 Old Hanover Rd.		48 HOURS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (has/have) attended the deceased from FEB 16, 1987, to FEB 17, 1987, that (I) (has) lost saw the deceased alive on FEB 17, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) view the body after death.										22c DATE SIGNED	
22b SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			22f DATE SIGNED
John L. Panko						FEB 17 1987					2/17/87
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL		23d LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		2/20/87		Evergreen Memorial		Finksburg		Carroll Co.		Md	
24 FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ELINE FUNERAL HOME Reisterstown Md.				FEB 19 1987		John Panko					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then shown to me, I will issue a burial permit. Then show this permit to the Funeral Director. Then show him this permit to the Health and Mental Hygiene office for burial permission, or if deceased was born in Maryland, to the State Dept. of Health and Mental Hygiene prior to burial permission, or if deceased was born outside Maryland, to the State Dept. of Health and Mental Hygiene prior to burial permission.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3704901			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
ALFRED A. G. Cook.						2 25 1987				0431 M			
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
MALE		B.		06 12 1905			81 YRS.		8 13				
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.						
Maryland		U.S.A.											
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL County Gen Hosp.		12a. USUAL OCCUPATION Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY						
Westminster		CARROLL County Gen Hosp.											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland										13c. COUNTY Carroll	13d. CITY OR TOWN Sykesville	13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13f. STREET ADDRESS / ZIP CODE 4820 Woodbine Rd., 21784
14. FATHER'S NAME FIRST Marshall		MIDDLE Cook		15. MOTHER'S MAIDEN NAME FIRST Bertie			MIDDLE Cross						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT 220-09-4162A, Della Cook, Same as # 13			ADDRESS						
No		220-09-4162A, Della Cook, Same as # 13											
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT										10 DAYS			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from FEB 15, 1987, to FEB 25, 1987, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 2/25/87			
22b. SIGNATURE Arthur L. Rudo, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur L. RUDO, M.D.		22e. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER, MARYLAND 21157											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-2-1987		23c. NAME OF CEMETERY OR CREMATORIAL Fairview			23d. LOCATION CITY OR TOWN Carroll, Md.		23e. COUNTY Carroll, Md.				
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR MAR 02 1987								25b. REGISTRAR'S SIGNATURE John J. Rudo			
DPHM - 16 60M 7/84 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18, shows only injury, or other significant condition contributing to death, attach a separate sheet.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3704102					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
Thelma May Corbin									Feb 28 87				8:20A		
3. SEX female			4 RACE White			5. DATE OF BIRTH MONTH 8 DAY 20 YEAR 1899			6. AGE (IN YEARS LAST BIRTHDAY) 86 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Carroll		MD.				
10 CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hosp. CTR			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b KIND OF BUSINESS OR INDUSTRY State						
13a STATE MN			13c CITY OR TOWN Baltimore			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 2828 ST. Paul ST.						
14 FATHER'S NAME FIRST MIDDLE LAST Oliver David Best			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arienetta Burck (Keller)												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 214-20-6186			17 INFORMANT Records, Springfield Hospital Ctr.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Cope's Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Pathological cardiovascular disease														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 2/28/87 to 2/28/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Byung H. Sohn															
22c. DEGREE															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Byung H. Sohn			22e. ADDRESS Springfield Hosp. CTR Sykesville MD			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED 2/28/87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 03-04-87			23c. NAME OF CEMETERY OR CREMATORIAL MT. OLIVET CEM.			23d. LOCATION CITY OR TOWN FREDERICK		COUNTY MD				
24 FUNERAL DIRECTOR NAME HAIGHT FUNERAL HOME SYKESVILLE, MD									25a. DATE REC'D. BY REGISTRAR MAR 05 1987		25b. REGISTRAR'S SIGNATURE via Davidson-Landress				

(initials) [unclear]

[unclear] [unclear]

1925 - Enclosed in the envelope.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
GRACE H. CORNELL												2-25-86				6AM
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Fe.			CAUC			MONTH DAY YEAR			70			MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			CARROLL COUNTY MD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR (TYPE OF WORK FOR MOST OF WORKING TIME) FACTORY							
100 WESTMINSTER			4049 LITTLESTOWN			PIKE			FACTORY							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
MD			CARROLL			WESTMINSTER						21157 PIKE				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. MEDIUM			4049 LITTLESTOWN PIKE WESTMINSTER				
JOHN			ANNIE KEISER			166-12-7443			21157			HILDA CORNELL 4049				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. IMMEDIATE CAUSE (a)			16c. IMMEDIATE CAUSE (b)			16d. IMMEDIATE CAUSE (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			PART I. DEATH WAS CAUSED BY HAS CVD													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			IMMEDIATE CAUSE (a)			IMMEDIATE CAUSE (b)			IMMEDIATE CAUSE (c)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF							
{			(b)													
{			DUE TO, OR AS A CONSEQUENCE OF													
{			(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
Severe Rheumatoid Arthritis; claudicatio																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) this hospital attended the deceased from April 19, 1973, to Feb 19, 1987, that (I) we last saw the deceased alive on April 19, 1987, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			2/25/87				
Gregorio C. Marfori, M.D.									49 Frederick St Taneytown, Md. 21787							
23a. BURIAL, CREMATION, REMOVAL (CITY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			Feb 28/87			MT VIEZCEM HARNEY CARROLL										
24. FUNERAL DIRECTOR			34 Moody Ave PA			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Ruthie Lavelle			Littlestown			FEB 27 1987			Julia Dawson-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate must be signed by the attending physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene (or Hospital or Funeral Director), or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

046536 MR 1157

04805

RECORDED BY
SIR JAMES
GUTHRIE

3

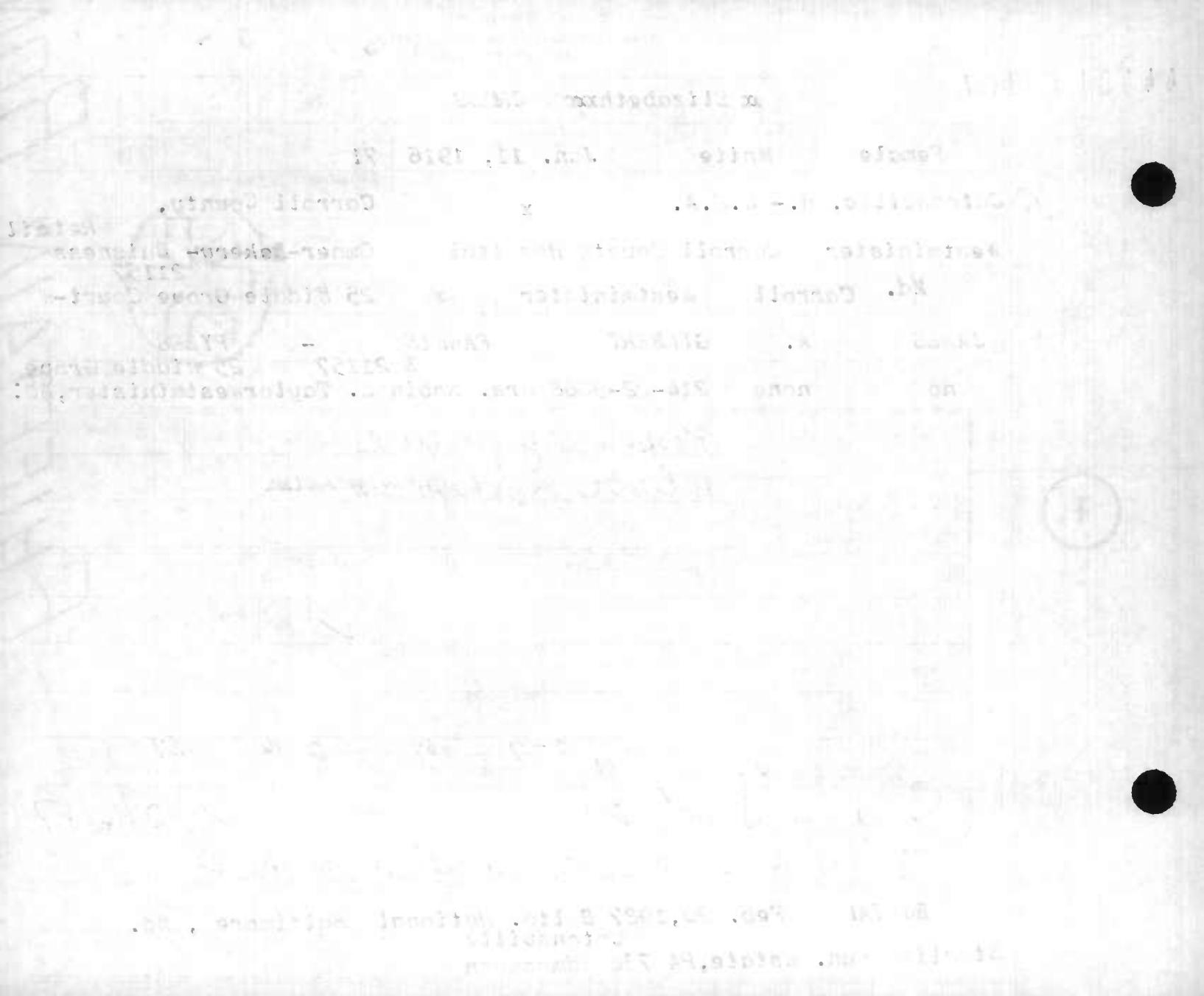
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please return to hospital or physician. To burial director: Please return to hospital or physician. To funeral director: Please return to hospital or physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, then medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. S 7 0 4 4 0 4			
1 - STATE REGISTRAR		2a DECEASED NAME (TYPE OR PRINT) Catherine Elizabeth Cross CROSS			MIDDLE		LAST		2b DATE OF DEATH 2/16/87	MONTH	DAY	YEAR	2b HOUR 0742
3. SEX Female		4. RACE White		5. DATE OF BIRTH Jan. 11, 1916			6. AGE (IN YEARS LAST BIRTHDAY) 71		# UNDER 1 YEAR YRS		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Catonsville, Md. - U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County,			MD.			
10. CITY OR TOWN OF DEATH Westminister		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Bakery Business			12b. KIND OF BUSINESS INDUSTRY Retail					
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Westminister		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS 25 Middle Grove Court-W		ZIP CODE 21157			
14. FATHER'S NAME JAMES		MIDDLE A.		15. MOTHER'S MAIDEN NAME GILBERT			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		PYLES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-22-9068			17. INFORMANT Z 21157		ADDRESS Mrs. Robin L. Taylor		25 Middle Grove Westminister, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral bronchopneumonia													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2-7 , 19 87 , to 2-16 , 19 87 , that (I) (we) last saw the deceased alive on 2-6 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Juan A. Suriel MD.										DEGREE		22c. DATE SIGNED 2/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN A. SURIEL MD.		22e. ADDRESS Carroll Co Gen. Hosp			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Feb. 20, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Balto. National			23d. LOCATION CITY OR TOWN Baltimore, Md.		COUNTY		STATE		
24. FUNERAL DIRECTOR Sterling Fun. Estate, PA		25a. DATE REC'D. BY REGISTRAR FEB 17 1987			25b. REGISTRAR'S SIGNATURE								
BP _____		ADDS			Catsville			FEB 17 1987					
DHMH - 16 60M 7/84 (VRA 15, 4)													



044054 FEE

17 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 / 04 905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. This page is to receive carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, death or traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Percy W. Clouse</i>						<i>2-4-87</i>				<i>3:12 P</i>	
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>Male</i>			<i>CAUCASIAN</i>	MONTH	DAY	YEAR	<i>90</i>	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>CARROLL CO.</i> MD.				
10. CITY OR TOWN OF DEATH <i>WESTMINSTER</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WESTMINSTER NURSING CENTER</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>DISABLED</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>NONE.</i>			
13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>CARROLL</i>	13c. CITY OR TOWN <i>WESTMINSTER</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1234 WASHINGTON RD. 21157</i>				
14. FATHER'S NAME FIRST <i>UNKNOWN</i>			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>UNKNOWN</i>			MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <i>YES</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) <i>W.W. I 219-20-0378</i>		17. INFORMANT ADDRESS <i>DR. IRV GOODMAN 55 E. MAIN ST 21157</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Pulmonary Failure</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>Sept 21 1982</i> to <i>Feb 4 1987</i> , that (1) (we) last saw the deceased alive on <i>Feb 3 1987</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated (above) (1) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>William R. Clouse MD</i>			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>2/4/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>FEB 6, 1987</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>WESTMINSTER CEM</i>		23d. LOCATION CITY OR TOWN <i>WESTMINSTER</i> COUNTY <i>CARROLL</i> STATE <i>MARYLAND</i>					
24. FUNERAL DIRECTOR NAME <i>MYERS FUNERAL HOME</i>			ADDRESS <i>WESTMINSTER, MD.</i>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Feb 10 1987 Julie Swanson Pendleton</i>						

RECEIVED
FEB 11 1968

LIBRARY



044357 FEB 3

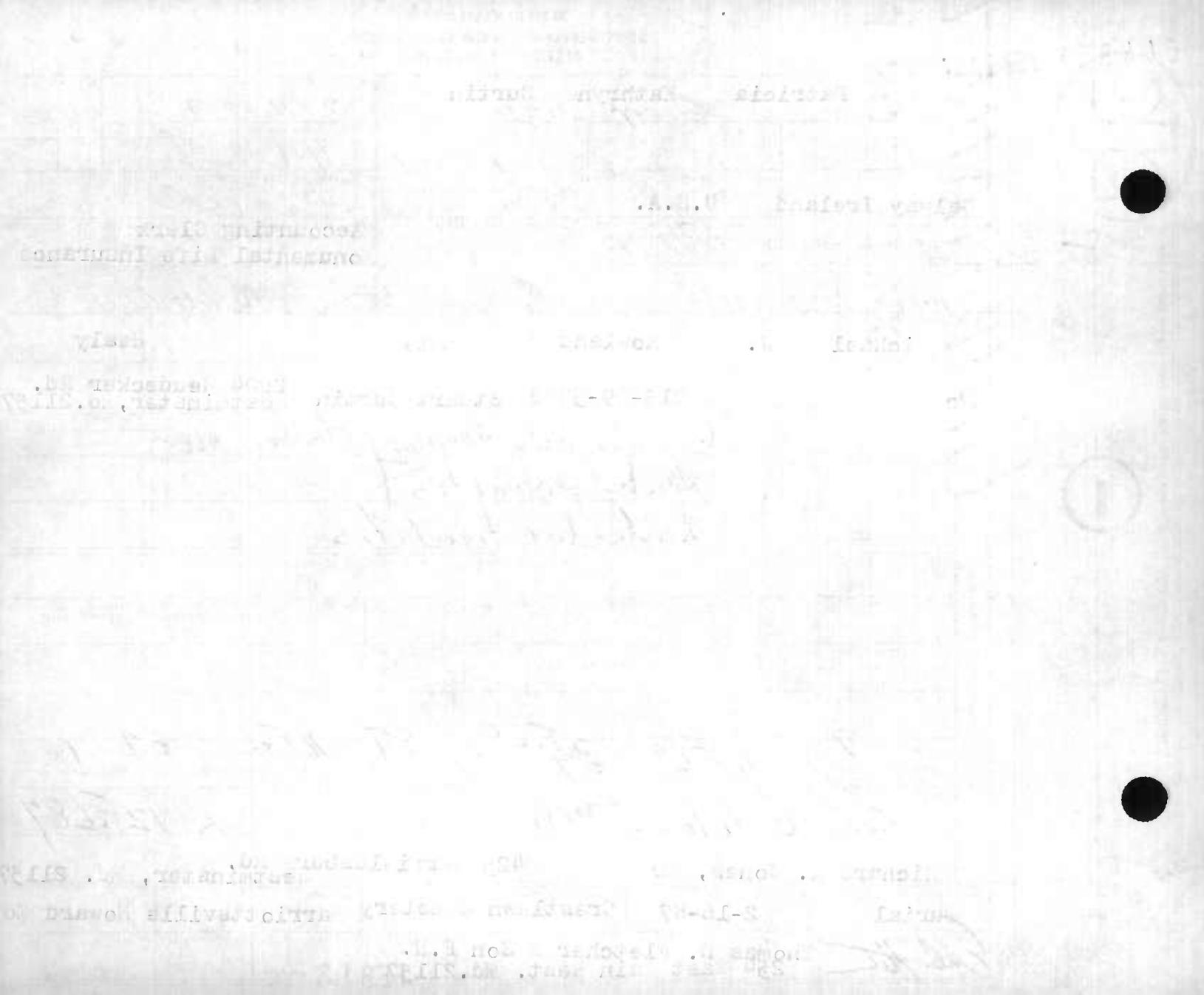
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use on the burial permit. Then please return carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. (removal, dismemberment, or removal)

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 010410					
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Patricia</i>	MIDDLE <i>Kathryn</i>	LAST <i>Curtin</i>	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
3. SEX			<input checked="" type="checkbox"/> F	4. RACE			<input checked="" type="checkbox"/> W	5. DATE OF BIRTH			MONTH 3	DAY 17	YEAR 17	6. AGE (IN YEARS LAST BIRTHDAY) 69	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i>							
11. CITY OR TOWN OF DEATH <i>Westminster</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) <i>C.C.H.</i>			12a. USUAL OCCUPATION <i>Accounting Clerk</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Monumental Life Insurance</i>								
13a. STATE <i>Md.</i>			13b. COUNTY <i>Carroll</i>			13c. CITY OR TOWN <i>Westminster</i>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS <i>2604 Neudecker Rd.</i>					
14. FATHER'S NAME FIRST <i>Michael</i>			MIDDLE <i>J.</i>	LAST <i>Rowland</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Kate</i>			16. SOCIAL SECURITY NO. <i>215-09-5338</i>			17. INFORMANT <i>Stuart Curtin</i>			ADDRESS <i>2604 Neudecker Rd. Westminster, Md. 21157</i>			
18. CAUSE OF DEATH (Enter only one cause of death for item 18, Part I, and item 1c) ~ PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause of death for item 18, Part I, and item 1c) ~ PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause of death for item 18, Part I, and item 1c) ~ PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause of death for item 18, Part I, and item 1c) ~ PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause of death for item 18, Part I, and item 1c) ~ PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)			DUE TO, OR AS A CONSEQUENCE OF (d)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>2 Feb 87</i>			21f. LOCATION STREET <i>87</i>			CITY OR TOWN <i>Westminster</i>			COUNTY <i>Carroll</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>2 Feb 87</i> , 19 <i>87</i> , to <i>11 Feb 87</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>11 Feb 87</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Richard A. Jones MD</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED <i>12 Feb 87</i>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard A. Jones, MD</i>			22f. ADDRESS <i>425 Warfieldsburg Rd. Westminster, Md. 21157</i>														
23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/> Burial			23b. DATE <i>2-16-87</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Crestlawn Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Marriottsville</i>			COUNTY <i>Howard</i>					
24. FUNERAL DIRECTOR <i>Thomas D. Fletcher & Son F.H.</i>			24a. DATE REC'D. BY REGISTRAR <i>FEB 13 1987</i>			25b. REGISTRAR'S SIGNATURE <i>John Fletcher</i>											
24b. ADDRESS <i>254 East Main West, Md. 21157</i>																	



044506 FEB 13

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

044501
REG. NO.

CB

1. DECEASED NAME (TYPE OR PRINT)		FIRST Mildred	MIDDLE Eloise	LAST Davis	2a. DATE KNOWN OF ESTI- MATED DAVIS	MONTH 2	DAY 9	YEAR 1987	2b. HOUR 1	
3. SEX Female	4 RACE White	5 DATE OF BIRTH MONTH Dec.	DAY 21	YEAR 1921	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YR. MONTHS 1	IF UNDER 24 HRS. DAYS 17	HOURS 0	MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co.,				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 408 Oak Hill Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress&Cook		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 408 Oak Hill Court, 21157					
14. FATHER'S NAME FIRST Dewey	MIDDLE 	LAST Disharoon	15. MOTHER'S MAIDEN NAME FIRST Florry		MIDDLE 	LAST Downs				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-10-6396		17. INFORMANT Gary E. Decker, Westminster, Md. 21157		122A Bond Street,				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a)</p> <p>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(b)</p> <p>X</p> <p>Atherosclerotic Cardiovascular Disease</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p> <p>Pulmonary Interstitial Fibrosis, marked</p>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?						
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
<p>22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</p> <p>Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE <i>Richard Jones</i></p> <p>M.D. <i>July</i> MEDICAL EXAMINER</p> <p>DATE SIGNED <i>11 Feb 87</i></p>										
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE Burial 2-14-1987		23c. NAME OF CEMETERY OR CREMATORIAL Ebenezer		23d. LOCATION CITY OR TOWN Winfield, Carroll, Md.				
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR FEB 17 1987		25b. REGISTRAR'S SIGNATURE						
DHMH - 17 (VR A15 ME(5)) 15M 7/77										

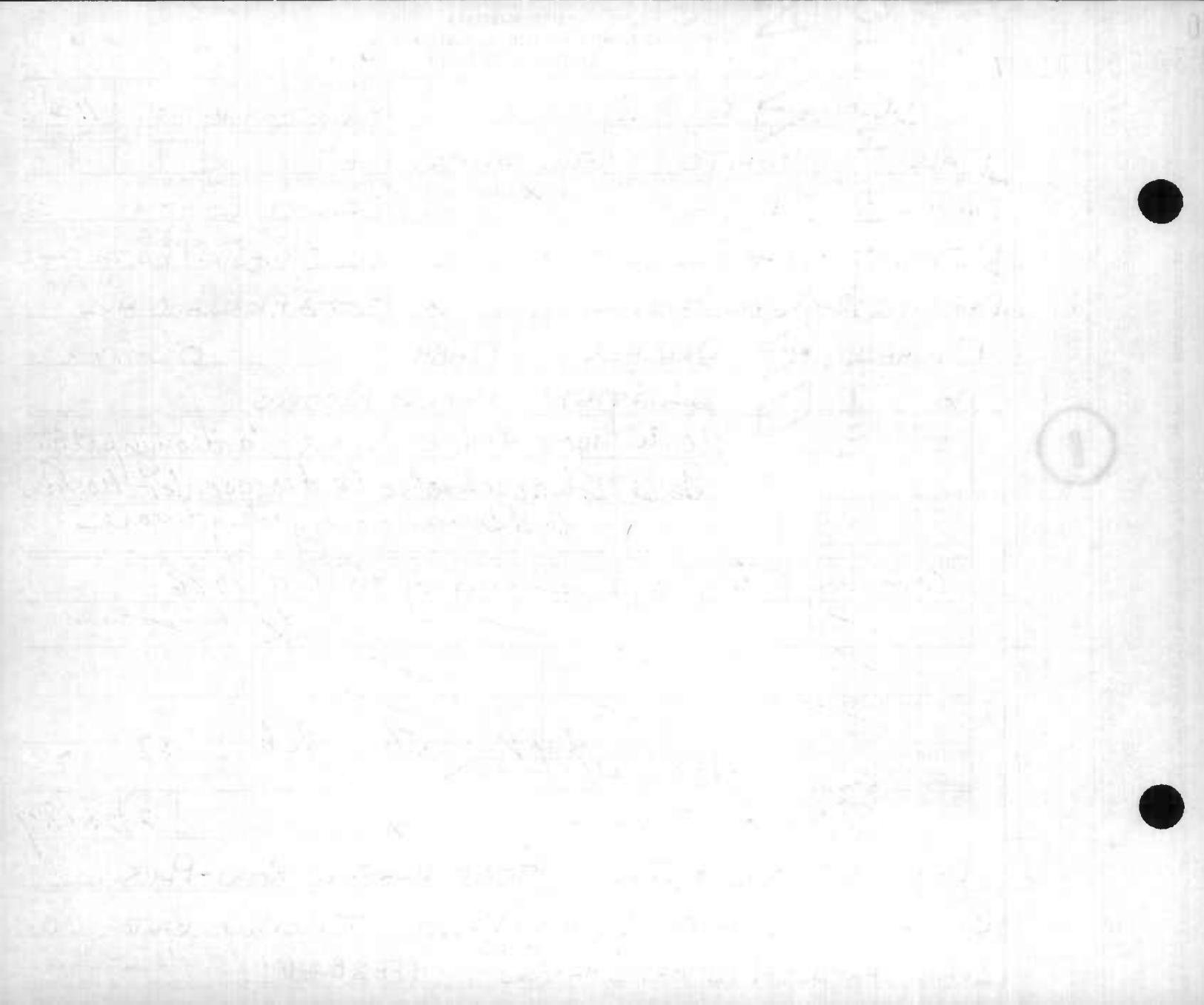
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove page 3 from the certificate. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other trauma, ask the attending physician to make a medical examination and attach a report.

MEDICAL CERTIFICATION

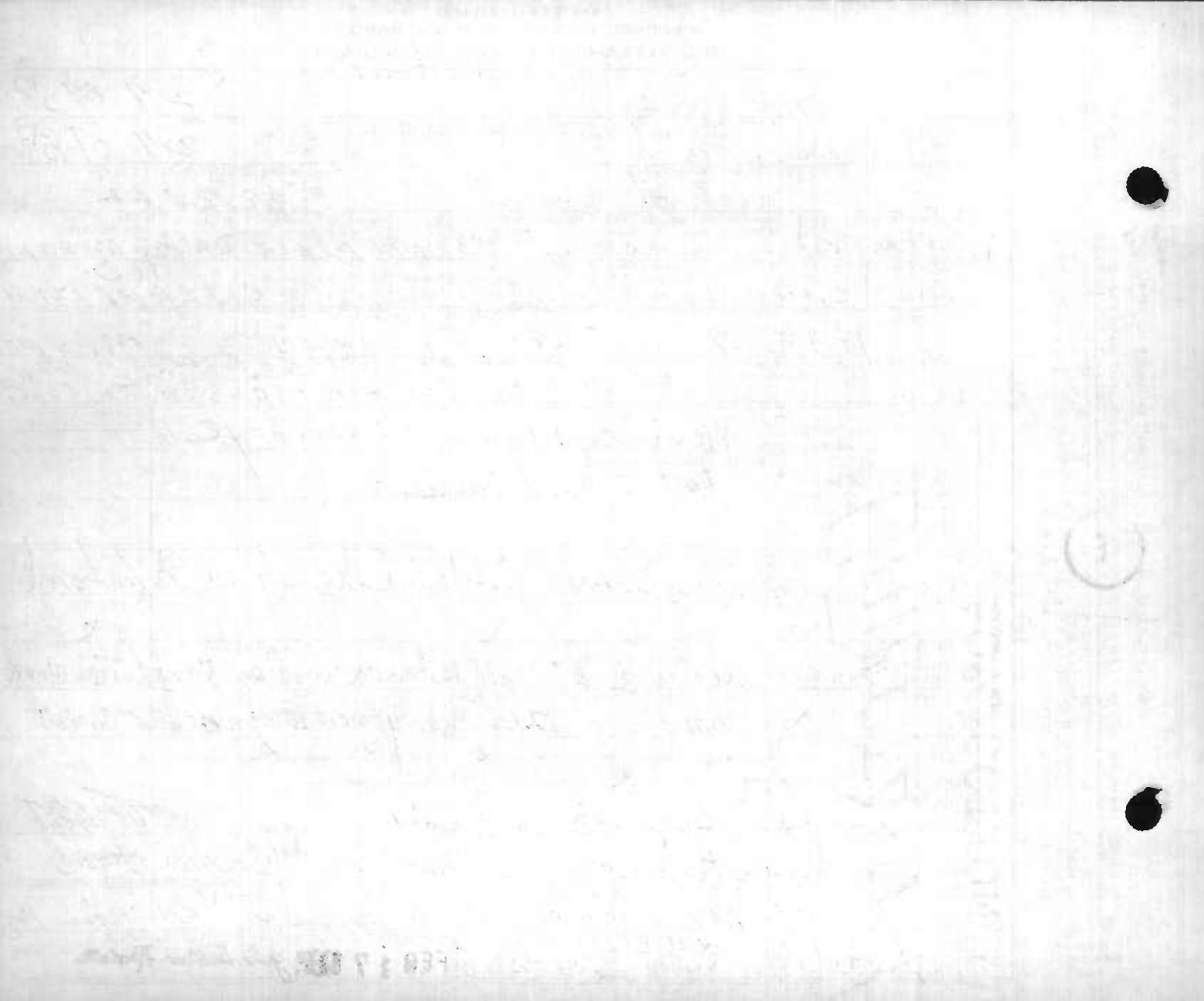
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8704408			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
CHARLES M. DELCHER									FEBRUARY 24, 1987			11:20 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
MALE		WHITE		MONTH DAY YEAR			MONTHS DAYS			MONTHS		HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			CARROLL COUNTY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
WESTMINSTER		CARROLL COUNTY GENERAL		13. STATE			13e. STREET ADDRESS / ZIP CODE			21234			
MARYLAND		Baltimore Parkville		13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3002 Moreland Ave.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Michael A. DELCHER		MARY O'Connor		216 129769			FAMILY RECORDS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		18. CAUSE OF DEATH (Enter only one cause per line for Part I.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for Part I.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No				DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Atherosclerotic Cardiovascular disease</u>			Acute Myocardial Ischemia - Cardiomyopathy						
				DUE TO, OR AS A CONSEQUENCE OF (c) <u>And Severe Coronary artery disease</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I. <u>Coronary artery bypass surgery on Aug 19 86.</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNINTENTIONAL <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR: A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)									
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY/TOWNSHIP			COUNTY		STATE	
22a. I certify that (i) (this hospital) attended the deceased from <u>12/23/87</u> to <u>1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) (I have) (we do) (do not) view the body after death.													
22b. SIGNATURE		22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED			
<u>Frank J. Kasik Jr.</u>		DR. FRANK J. KASIK, JR.								2/26/87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			
BURIAL		2-28-1987		Duhane Valley			Timonium			Balto. MD.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Evans Chapel of Memories HARFORD		8800 ROAD		FEB 26 1987			Julia Davidson-Lundee						



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 04904								
FOR STATE REGISTRAR			LAST <i>Butterfield</i>																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE KNOWN & OF ESTI. DEATH MATED			MONTH DAY YEAR								
<i>MARY E.</i>									<input type="checkbox"/> 27 87 15 PM			2b. HOUR								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR						
Fe		Cauc		Oct 13 14 72RS.								27 87 15 PM		2d. HOUR						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>CARROLL</i>														
MD		USA																		
10. CITY OR TOWN OF DEATH <i>WESTMINSTER</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CARROLL HOSPITAL</i>									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>BLACK-DECKER ASS ENGR</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>2152 RD. WESTMINSTER</i>					
13a. STATE MD			13b. COUNTY <i>CARROLL</i>			13c. CITY OR TOWN <i>WESTMINSTER</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1245 CHERRY TOWER</i>									
14. FATHER'S NAME FIRST <i>J. HARVEY</i> MIDDLE <i>ALTER</i> LAST			15. MOTHER'S MAIDEN NAME FIRST <i>FLORENCE</i> MIDDLE <i>MYERS</i> LAST																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>212-01-8644</i>									16c. ADDRESS <i>WESTMINSTER MD 2152 CHERRY TOWER</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <i>888</i>			IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF <i>acute Subdural Hemorrhage</i>																	
			(b) DUE TO, OR AS A CONSEQUENCE OF <i>Fall & Head fracture</i>																	
			(c)																	
19a. MEDICAL CERTIFICATION			PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Avascular Tapering Chronic Subdural Hematoma Scoliosis</i>									19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WHERE UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>Noon 2-3 87</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II) <i>Fell & struck head on grandfather's clock</i>			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>home</i>			21e. LOCATION STREET <i>1245 Cherry tower</i>			21f. CITY OR TOWN <i>Westminster Carroll</i>					
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>																				
22a. Identify that I took charge of the remains described above, held an death resulted from Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>																	
ACTUAL SIGNATURE <i>Richard A. Jones</i>			TITLE (SPECIFY) <i>Deputy</i>									M.D.			MEDICAL EXAMINER <i>Richard A. Jones</i>					
EXAMINER'S NAME (TYPE OR PRINT)																		DATE SIGNED <i>7 Feb 87</i>		
23a. BURIAL/CREMATION/REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2/10/87</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>SEMGARY'S CEM.</i>			23d. LOCATION CITY OR TOWN <i>SILVER SPRING</i>			23e. COUNTY <i>CARROLL</i>			23f. STATE <i>MD</i>					
24. FUNERAL DIRECTOR NAME <i>Ronald L. Jones Jr.</i>			ADDRESS <i>Littleton Ln 5734 Myrtle Cr</i>			25a. DATE REC'D. BY REGISTRAR <i>FEB 17 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORDS "DEATH DULY NOTIFIED" IN PENCIL, IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 19A, 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 1 SHOULD BE USED AS A BRIEF TRANSMIT REPORT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME(5))
15M 7/77



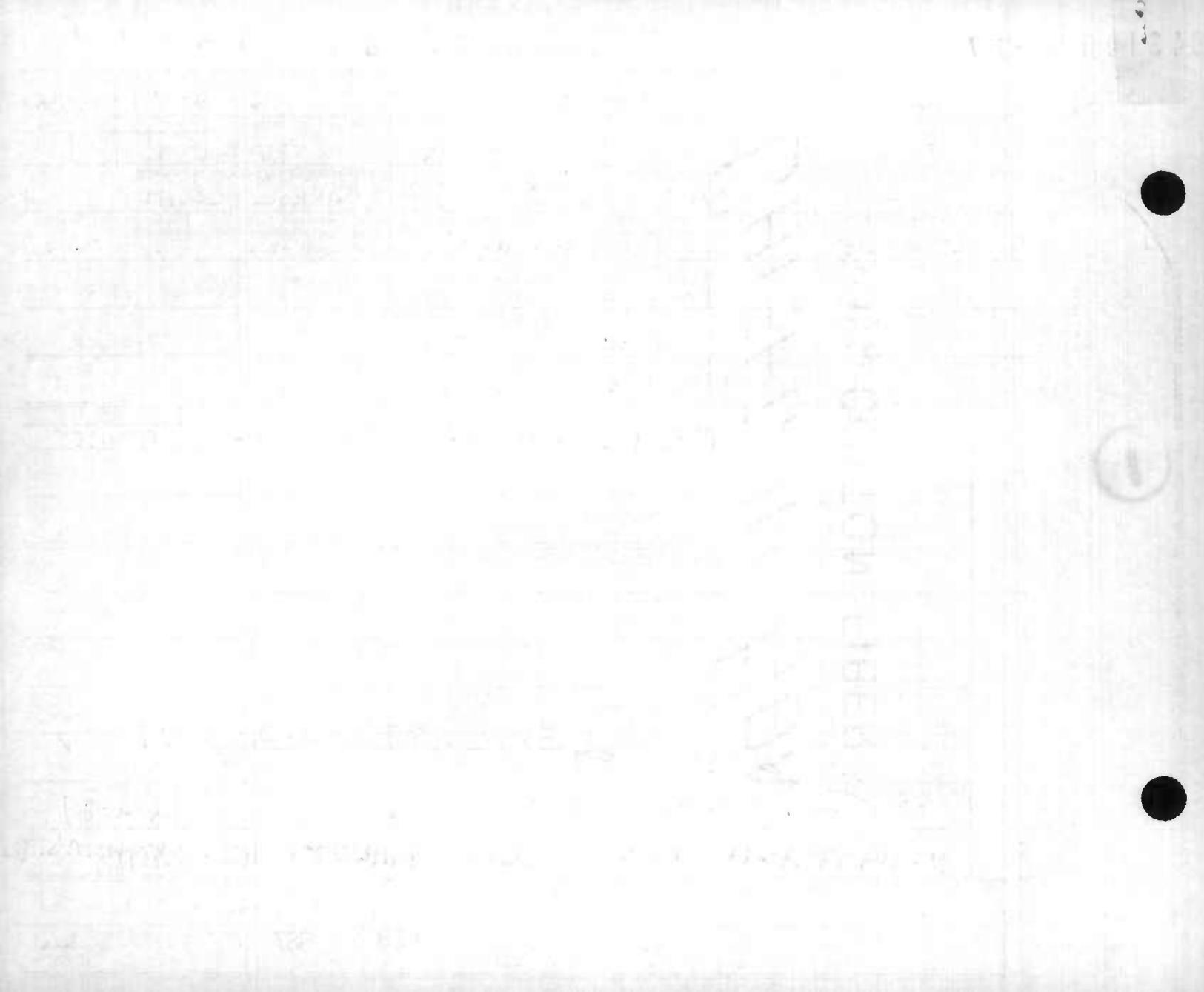
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the Burial-Death Permit. Then please return carbon paper. Pages 1 and 2 should be filed with the State Health and Mental Hygiene office to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be called in to make an examination.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8704910	
1. DECEASED NAME (TYPE OR PRINT)		FIRST EDNA	MIDDLE M.	LAST DUGAN	2a DATE OF DEATH		MONTH 2	DAY 2	YEAR 87	2b HOUR 0553AM	
3. SEX F Female		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 3 YEAR 13		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS 74 YRS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.					
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION CARROLL COUNTY GEN Hospital		12a. USUAL OCCUPATION Hairstresser		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store					
13a. STATE MD		13b. COUNTY Frederick		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15536 Liberty Road 21771			
14. FATHER'S NAME FIRST Benjamin		MIDDLE F.	LAST Hilgert	15. MOTHER'S MAIDEN NAME FIRST Florence		MIDDLE V.	LAST Kroeger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-14-5177		17. INFORMANT Maurice Dugan		ADDRESS Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC LUNG CANCER										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-31-87 to 2-2-87, that (I) (we) last saw the deceased alive on 2-1-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE N. Carbone		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 2-2-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. RASPBERRY MD		22e. ADDRESS 224 WASHINGTON HB. WESTMINSTER MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/5/87		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn Cemetery		23d. LOCATION CITY OR TOWN Marriottsville COUNTY Maryland STATE					
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. FEB 3 1987		5555 Twin Knolls Road, Columbia, MD. 21045		25a. DATE RECEIVED BY REGISTRAR FEB 3 1987		25b. REGISTRAR'S SIGNATURE Julia Jackson-Randall					
DHMH - 16 60M 7/84 (VRA 15. 4)											

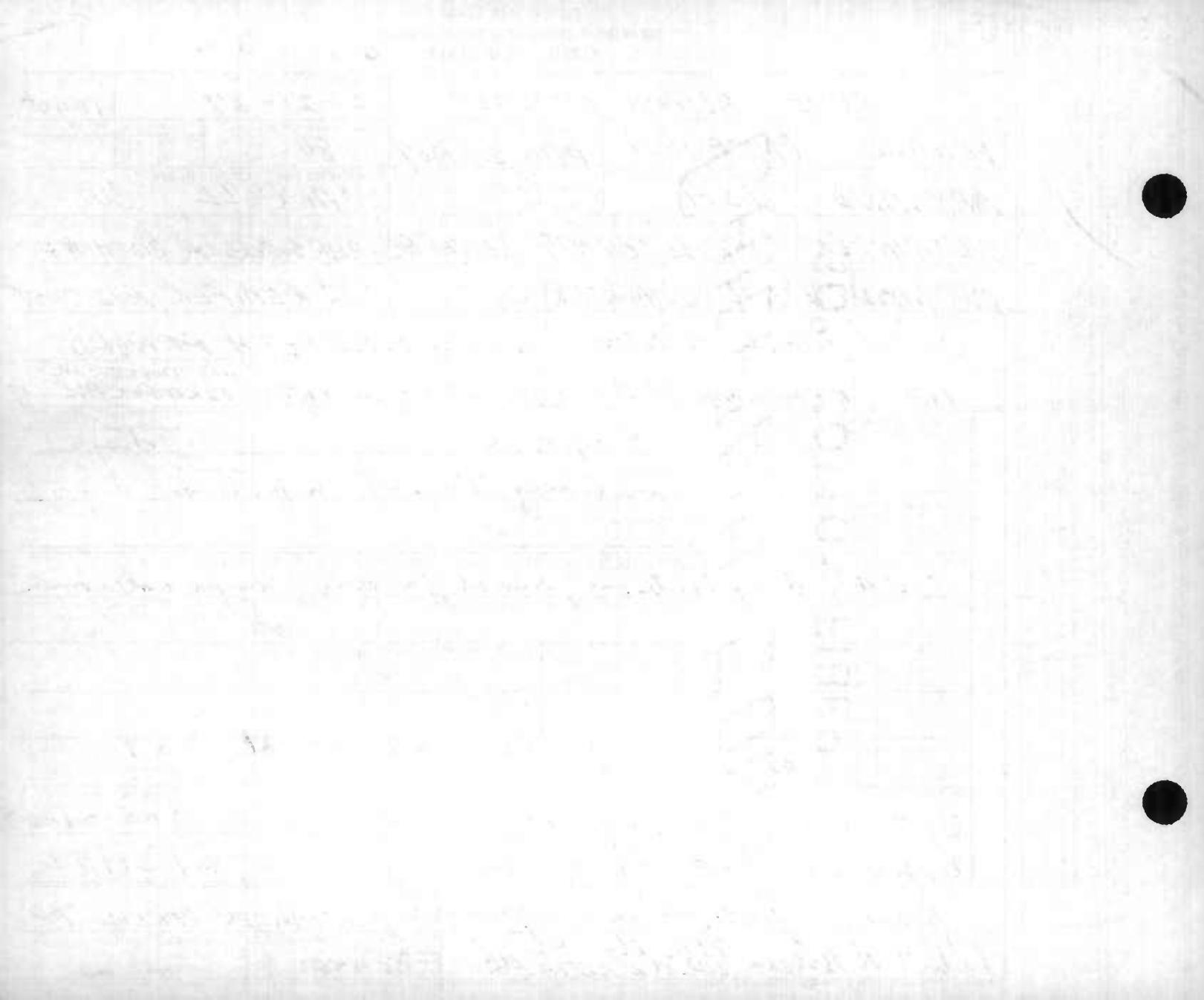


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed - plus 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 87 04911
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
SUSIE HESSON DUTTERER						2 - 21 - 87			11 40 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
FEMALE		CAUCASIAN		FEB 29 1987			80 YRS.					
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL CO. MD.					
MARYLAND		U.S.A.										
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOOR SUPERVISOR CLOTHING			12b. KIND OF BUSINESS OR INDUSTRY					
MARYLAND		CARROLL COUNTY WESTMINSTER										
13a. STATE MARYLAND		13b. COUNTY CARROLL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 12 KEMPER AVE 21157					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME NANCY ELIZABETH ARNOLD										
JOHN DANIEL ZINCON												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NOT APPLICABLE 213-09-5406		17. INFORMANT MELTING DUTTERER			ADDRESS WESTMINSTER MD. 12 KEMPER AVE 21157			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) coronary Tract infection days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.												
DUE TO, OR AS A CONSEQUENCE OF (c) days												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) cva, deby drahion, renal failure, hypocalcemia												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 02-17, 1987, to 02-29, 1987, that (I) (we) lost sow the deceased alive on 02-21, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Ephraim Bakaga M.D.		22c. DEGREE		22d. DATE SIGNED 02-21-87								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Ephraim Bakaga		22f. ADDRESS NEW WINDSOR, MD. 21774										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE FEB 26, 1987		23c. NAME OF CEMETERY OR CREMATORIAL WESTMINSTER CEMETERY			23d. LOCATION CITY OR TOWN WESTMINSTER COUNTY CARROLL MD. STATE					
24. FUNERAL DIRECTOR NAME Robert A. Myers		25a. DATE REC'D. BY REGISTRAR FEB 24 1987		25b. REGISTRAR'S SIGNATURE John Decker								



TO HOSPITAL OR ATTENDING PHYSICIAN. The
attended by the hospital or attending physician.

and may be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then place above carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. **Cremation** [initials] **REMURIAL** [initials]

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 4 9 1 2

DECESSED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
<u>mary pauline Ege</u>						<u>2 3 87</u>				<u>0350m</u>
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS				
<u>F</u>	<u>w</u>	MONTH <u>3</u> DAY <u>7</u> YEAR <u>1917</u>	69	YEARS	MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
<u>Maryland</u>	<u>USA</u>						<u>Carroll County</u>			
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
<u>Westminster</u>	<u>Carroll County General Hospital</u>					<u>Hwf</u>				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a STREET ADDRESS / ZIP CODE				
13a. STATE <u>Md.</u>	13b. COUNTY <u>Carroll</u>	13c. CITY OR TOWN <u>Westminster</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	2319 Carrollton Road 21157						
14. FATHER'S NAME FIRST <u>George</u> MIDDLE <u></u> LAST <u>Richards</u>			15. MOTHER'S MAIDEN NAME FIRST <u>M.</u> MIDDLE <u>Evelyn</u> LAST <u>Sadler</u>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>			16b SOCIAL SECURITY NO. <u>218-10-2656</u>		17 INFORMANT Mr. John F. Ege, Westminster, Md.		ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>8664</u>			IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) _____							
			(c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>LITHIUM TOXITY, RESWOOD CVA</u>										
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)							
21d INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>1127</u> , 19 <u>87</u> , to <u>213</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>213</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>Howard G. Lanham MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <u>2/1/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
<u>Howard G. Lanham, M.D.</u>			<u>215 Washington Hgt Med. Ctr, Westminster,</u>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN	MD 21157		STATE			
<u>Burial</u>	<u>2-5-87</u>	<u>Holly Hill Mem. Park</u>		<u>White Marsh</u>	<u>Balto</u>		<u>Md.</u>			
24 FUNERAL DIRECTOR NAME <u>Eline Funeral Home, Hampstead, Md.</u>			ADDRESS		25a DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>FFB 6 1987</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use by the burial permit office. Then please remove coupon from page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 18 is marked or item 21 is marked, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8704915			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			26. HOUR				
EDWARD C. FELGENHAUER						2 13 87			11:20 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 23 HRS.	
MALE		CAUCASIAN		1 9 97			90 YRS.			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
ILLINOIS		U.S.A.					CARROLL COUNTY MD.			WESTMINSTER			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			
CARROLL W.H. VILLAGE HCC SUP. ACCOUNT. DEPT.										12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE COUNTY CITY OR TOWN										13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
25 MARYLAND CARROLL WESTMINSTER										13e. STREET ADDRESS ZIP CODE 214 ST. MARLWAY 21157			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
LOUIS		FELGENHAUER		AUGUSTA		Mueller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		216-03-2936		MABEL J. FELGENHAUER		214 ST. MARLWAY							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week			
Acute bronchitis													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause last													
(b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
Adult onset diabetes mellitus; Progressive cerebrovascular insufficiency													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/14/87 19 to now 19, that (I) (did) (not) (do) (what) (else) (to) (the) deceased alive on 2/14/87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) (do) (what) (else) (to) (the) deceased after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/14/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. CORKEE M.D.		22e. ADDRESS P.O. Box 71, Union Bridge, MD 21781											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2-14-87		23c. NAME OF CEMETERY OR CREMATORIAL Carroll Cremation		23d. LOCATION CITY, TOWN HAMPSTEAD		COUNTRY CARROLL		STATE MD			
24. FUNERAL DIRECTOR NAME ELINE FUNERAL HOME		ADDRESS HAMPSTEAD MD		25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE FEB 18 1987 Julia Davidson-Landreke									

Archaeological Survey of India

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1 RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 04914			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI. DEATH MATED			2b. HOUR MONTH DAY YEAR				
KENNETH B. FISCHER						<input checked="" type="checkbox"/> 2-25-87 ₁₉			2d. HOUR MONTH DAY YEAR				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2-25-87 ₁₉			7:18A			
Male	White	2 17 63	24 yrs.	MONTH DAYS	HOURS MIN								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Carroll County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Westminster		Carroll Co. General Hospital			Manager			Warehouse					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		MD.			
Md.		Carroll		Hampstead				2801 Willow View Ct. 21074					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		ADDRESS									
Gordon Fischer		Sarah E. Covington											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> no			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
			213-88-1269			Mrs. Sarah Fischer, Hampstead, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o) stating the under- lying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 o													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Margarita A. Korell</i> M.D. Assistant MEDICAL EXAMINER TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Pen Street DATE SIGNED 2-26-87													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
Burial		2-27-87		Hampstead Cemetery			Hampstead		Carroll		Md.		
24. FUNERAL DIRECTOR <i>Eline Funeral Home</i>		ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
							MAR 10 1987		<i>Julie Sander-Lindner</i>				

1960 LORAN

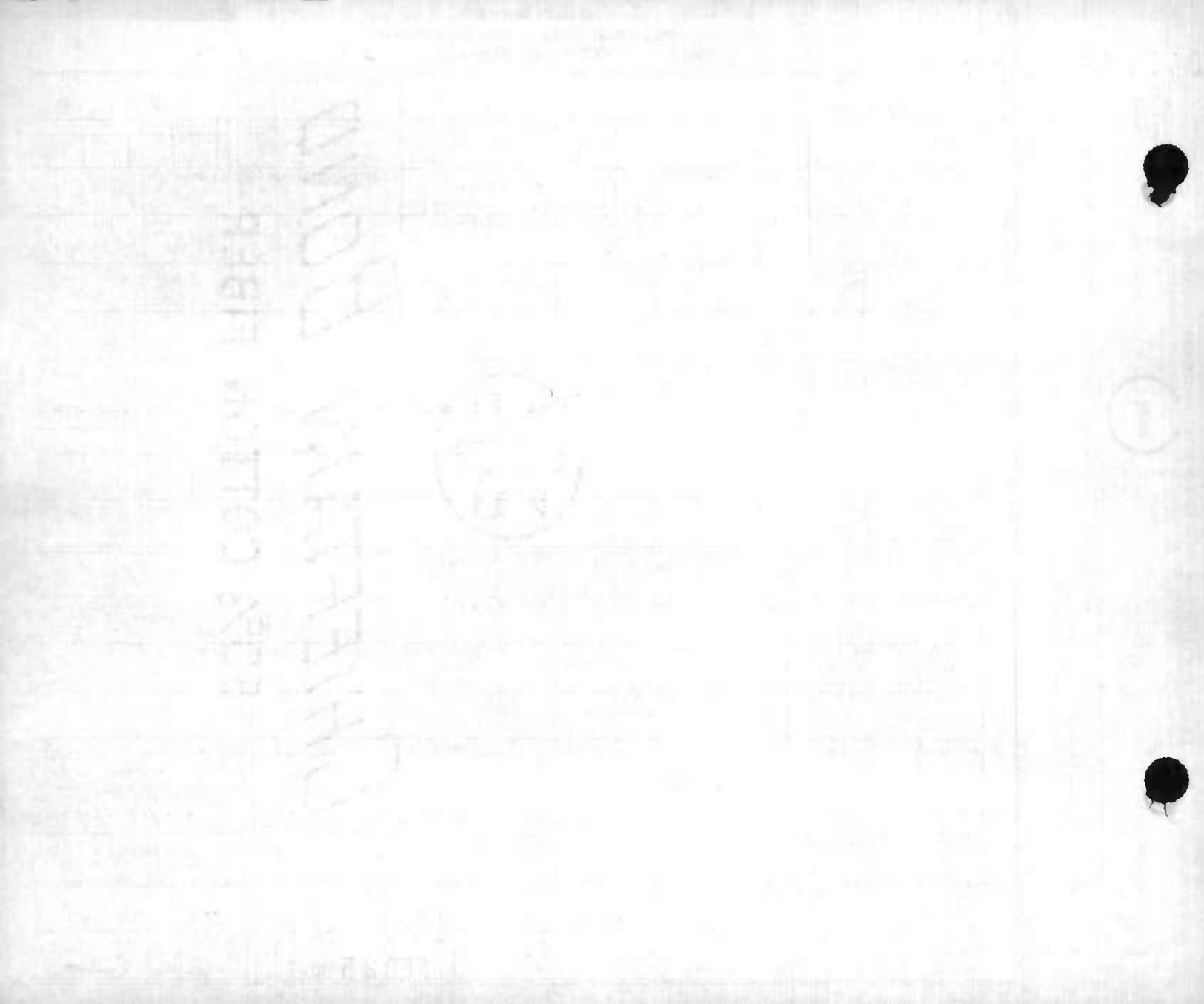
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 / 04915	
1. DECEASED NAME (TYPE OR PRINT) DAPHNE B. GOETZKE				2a. DATE OF DEATH MONTH DAY YEAR 2 19 87				2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 12 PM					
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06 12 03			6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.						
10. CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRHAVEN		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Civil Service			12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov't.						
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7200 Third Avenue 21784				
14. FATHER'S NAME FIRST Edgar		MIDDLE LAST Bunn		15. MOTHER'S MAIDEN NAME FIRST Latisha			MIDDLE LAST Zumwalt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-20-0681		17. INFORMANT Mr. Louis Goetzke			ADDRESS 21784 Sykesville, MD						
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Anapathic carcinoma</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/5 , 19 86 , to 2/19 , 19 87 , that (I) (we) last saw the deceased alive on 2/11 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 2/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICK TURNES, MD		22e. ADDRESS 7200 THIRD Ave Sykesville, MD 21784											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 02-20-87		23c. NAME OF CEMETERY OR CREMATORIAL CARROLL CREMATION SERV		23d. LOCATION CITY OR TOWN HAMPSTEAD		COUNTRY CARROLL		STATE MD			
24. FUNERAL DIRECTOR NAME HAIGHT FUNERAL HOME		ADDRESS SYKESVILLE, MD 21784		25a. DATE REC'D. BY REGISTRAR FEB 23 1987		25b. REGISTRAR'S SIGNATURE <i>J. Wilson Landers</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal or removal of body. If item 21 is marked, the medical examiner must be notified at once.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other hazard

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 / 0 4 9 1 0		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Mary A Gordon						2a. DATE OF DEATH	25	87		10:25AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		White		MONTH 4	DAY 27	YEAR 1888	98		YRS	MONTHS	DAYS	IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			HOURS MIN.	
Ohio land		U.S.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Carroll				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Mt. Airy		Pleasant View Nursing Home			Saleswoman			Stationary				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. STREET ADDRESS / ZIP CODE			
Md.		Howard		Columbia		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			10799 Hickory Ridge Rd. 21044			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Adam			Sutton	Josephine				MIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS							
No		215-01-9368			Joy Wood 3608 Cameron Ct., Ellicott City, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for 10, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u>												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiac atherosclerosis and arrhythmia</u> YES (c) <u>renal failure</u> YES												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Anemia, renal failure, hypertension</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (if this hospital) attended the deceased from <u>12/29/87</u> , 19 <u>87</u> , to <u>2/25</u> , 19 <u>87</u> , that (if we) last saw the deceased alive on <u>2/15/87</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here) <input type="checkbox"/>												
22b. SIGNATURE <u>Melvin Gordon MD</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>2/25/87</u>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Melvin J Gordon MD</u>		22f. ADDRESS <u>2000 Century Plaza</u>			<u>Columbia</u>			<u>Md. 21044</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/28/87		23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn			23d. LOCATION CITY OR TOWN Ellicott City, Ho.		COUNTY	STATE Md.		
24. FUNERAL DIRECTOR Harry H. Witzke & Family Funeral Home, Inc.		25a. DATE REC'D. BY REGISTRAR MAR 04 1987			25b. REGISTRAR'S SIGNATURE <u>Jane Gordon Residele</u>							

DHMH - 16 60M 7-84
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please retain the first two pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

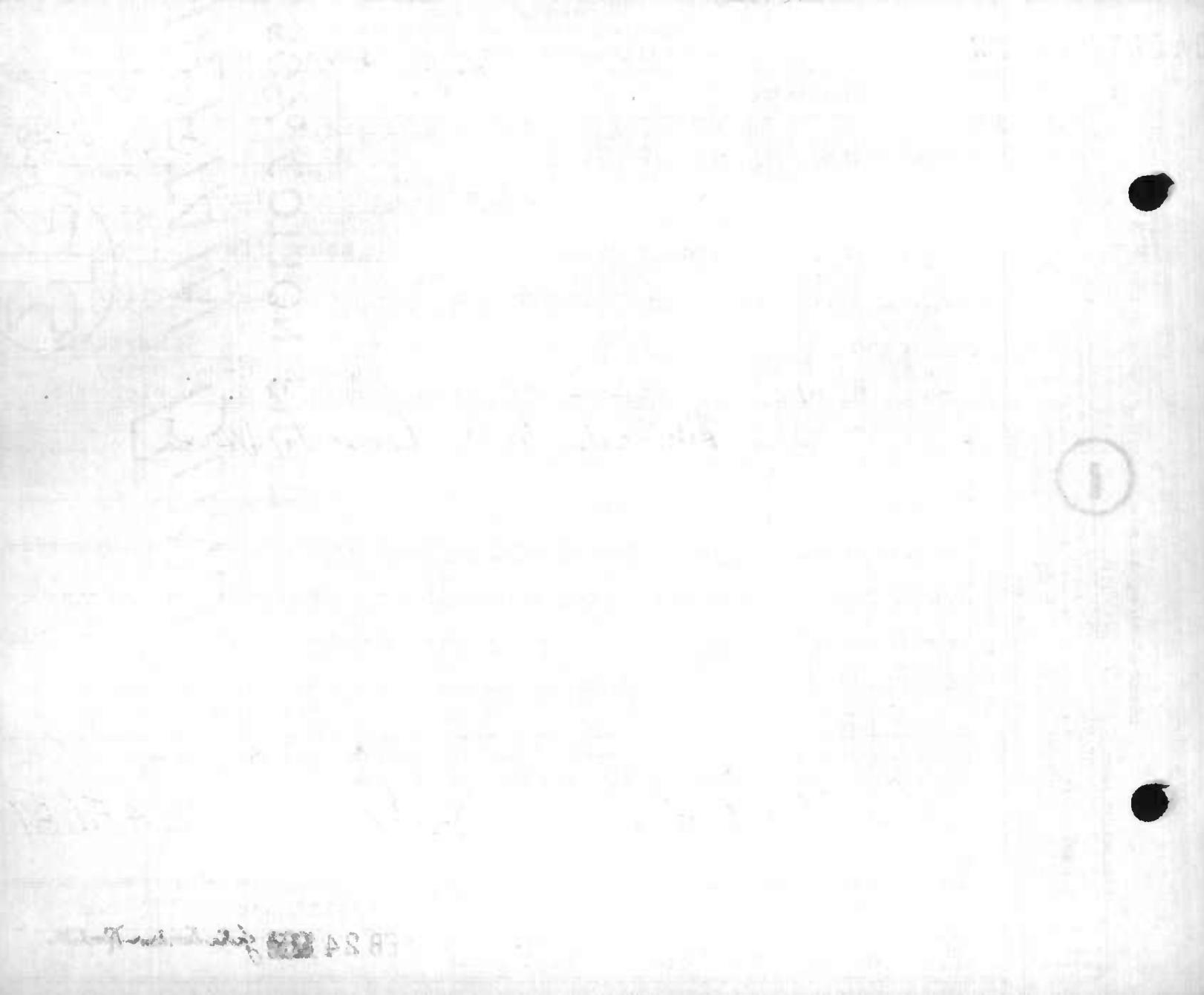
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 04911	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
Giovanni			Greco			February 23, 1987			9:30 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		Caucasian		1-16-1899			88 YRS.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Italy		Italy					Carroll County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Westminster		Carroll County General Hospital		Horticulturist			Balto City				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Maryland		Howard		Sykesville						14236 Forsythe Rd. 21784	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Giovanni Greco		Anna Cicero									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		216-36-8918		Sykesville			MD 21784				
Mrs. Francesca Greco		14236 Forsythe Rd.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Loring Byers</u>		22c. DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>2/28/87</u>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 2-26-87		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Mausoleum			23d. LOCATION CITY OR TOWN Pikesville			COUNTY	STATE Baltimore MD
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133		25a. DATE REC'D. BY REGISTRAR MAR 02 1987		25b. REGISTRAR'S SIGNATURE <u>Jeanne L. L. Greco</u>							

3

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 045474 FEB 27 1987

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OR ESTI. DEATH MATED	MONTH	DAY	YEAR	b. HOUR	
Elizabeth			J.	Hargis		2 12	87	19			
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Female	white	10 19 05	81 yrs.	MONTHS	DAYS	HOURS	MIN.	2 14	87	30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Md		USA					Carroll				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Westminster		606 Locust House			housewife		home				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Md	Carroll	Westminster	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		606 Locust St 21157						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
Ferdinand			Bernhard	Frances			Hartzell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no		n/a		214-40-9123		Niantic, Conn. 06357		Steve Hargis 32 S. Cobblers Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion			
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Carroll Hargis</i>		TITLED (SPECIFY) M.D.		Deputy		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/18/87		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN Baltimore		COUNTY		STATE Md	
24. FUNERAL DIRECTOR NAME PRITTS FUNERAL HOME		ADDRESS Westminster, Md 412 Washington Rd		25a. DATE OF DAY DEATH FEB 24 1987		25b. TIME OF DAY DEATH 10:00 AM		25c. PLACE OF DEATH Westminster, Md			
BP											
DHMH-17 (VR A15 ME (5))											
15M 2/80											



HOSPITAL OR ATTENDING PHYSICIAN. The one requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit form. Pages 1 and 2 should be filed with the health department after death, until burial, entombment, or removal.

IMPORTANT: If Item 31 is marked, you must show every

MEDICAL CERTIFICATION

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8704919
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Austin Augustus			2a. DATE OF DEATH MONTH DAY YEAR 2-17-87 1605M		
3. SEX male		4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 24 1918		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian.
13a. STATE Maryland		13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 60 Charles St. / 21157
14. FATHER'S NAME FIRST George		MIDDLE J.	LAST Howard Sr	15. MOTHER'S MAIDEN NAME FIRST Minnie	MIDDLE Jackson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-14-2130		17. INFORMANT ADDRESS Sharon R. Magruder 200 Spruce Ct	Frederick, Md 21701
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic liver disease primary unknown DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia:					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 9-4-1987 to 9-17-1987 , that (I) (we) last saw the deceased alive on 9-17-1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE CHITRACHEDU NAGANNA		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NAGANNA		22e. ADDRESS 700 A poole Rd Westminster MD 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-20-87	23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive Cemetery	23d. LOCATION CITY OR TOWN New Windsor	COUNTY Carroll STATE MD
24. FUNERAL DIRECTOR NAME D. D. Hartzler		ADDRESS Union Bridge, Md	25a. DATE RECORD IS RECEIVED FEB 20 1987	25b. REGISTRATION SIGNATURE Taylor Landes	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 18 is marked or if item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8704920
1. DECEASED NAME (TYPE OR PRINT)	FIRST <i>Oscar</i>	MIDDLE <i>J</i>	LAST <i>Humbert</i>	2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>2-7-87 1450M</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>3 18 1896</i>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS <i>90 YRS</i>	IF UNDER 24 HRS HOURS MIN. <i></i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PA.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll Co.</i>	
10. CITY OR TOWN OF DEATH <i>Westminster</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll Co. Gen. Hosp.</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>printer</i>
13a. STATE <i>Md</i>	13b. COUNTY <i>Carroll</i>	13c. CITY OR TOWN <i>Westminster</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>201 ST MARK WAY APT 312</i>
14. FATHER'S NAME FIRST <i>REUBEN</i>	MIDDLE <i>J</i>	LAST <i>HUMBERT</i>	15. MOTHER'S MAIDEN NAME FIRST <i>LAVINIA</i>	MIDDLE <i></i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>	16b. SOCIAL SECURITY NO <i>n/a</i>	17. INFORMANT <i>EVA HUMBERT</i>	18. ADDRESS <i>13e 21157</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i>8583</i>				
(b) <i>Ventricular Tachycardia</i>			minutes	
(c) <i>Atherosclerotic cardiovascular disease years</i>			minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>serpiginous disorder; Quinidine Toxicity; chronic cardiomegaly</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>2-05-1987</i> to <i>2-07-1987</i> , that (I) (we) last saw the deceased alive on <i>2-07-1987</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Ephraim Barzaga M.D.</i>	22c. DEGREE	22d. DATE SIGNED <i>2-7-87</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Ephraim Barzaga</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>	23b. DATE <i>2/10/87</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Kriders</i>	23d. LOCATION CITY OR TOWN <i>Westminster</i>	COUNTY STATE <i>Carroll Md</i>
24. FUNERAL DIRECTOR NAME <i>Robert Kyle Brilla Jr. Westminster, Md.</i>	ADDRESS	25a. DATE REC'D. BY REGISTRAR / REGISTRAR'S SIGNATURE <i>FEB 13 1987 Julia Landon-Lambeth</i>		

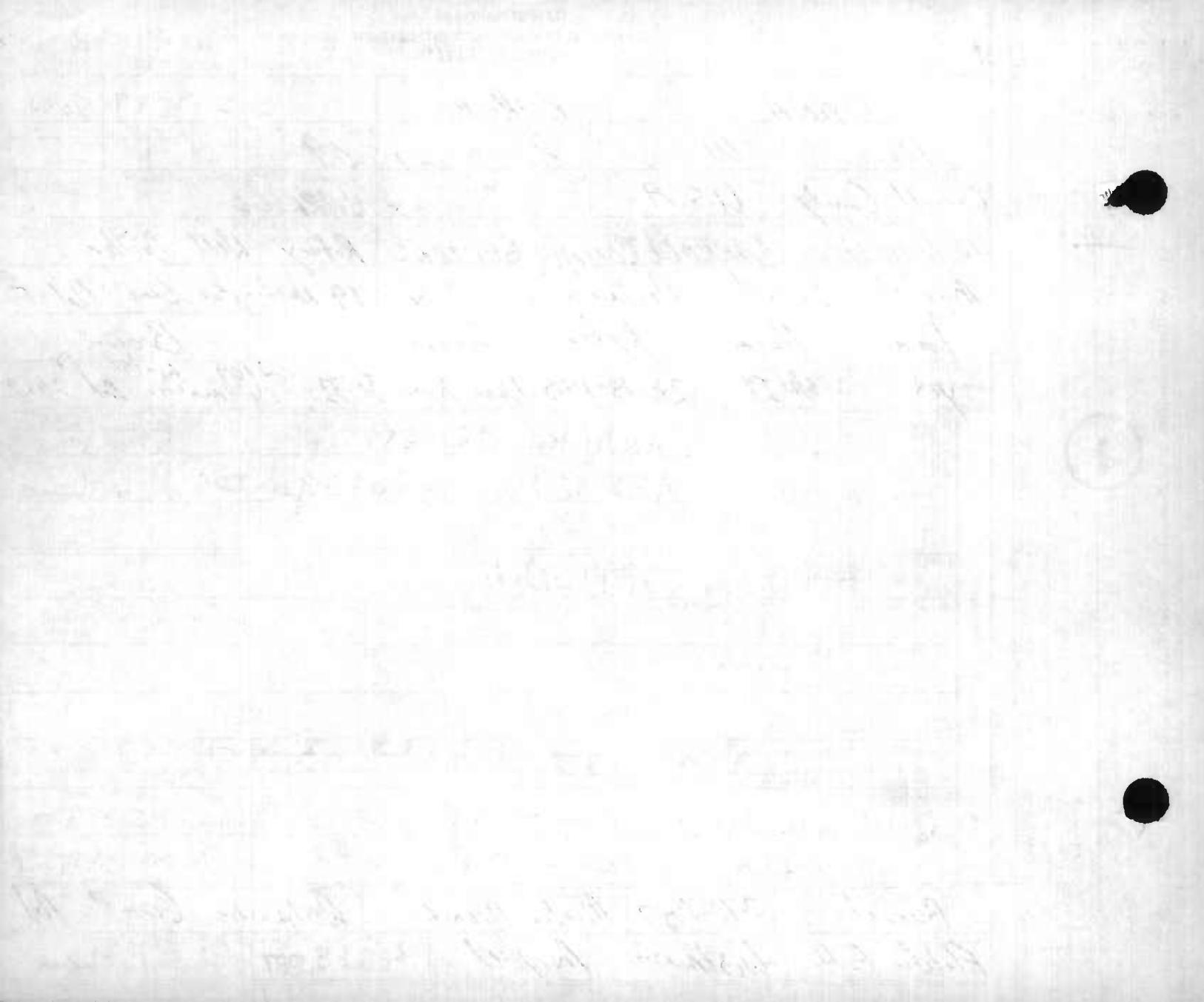
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.

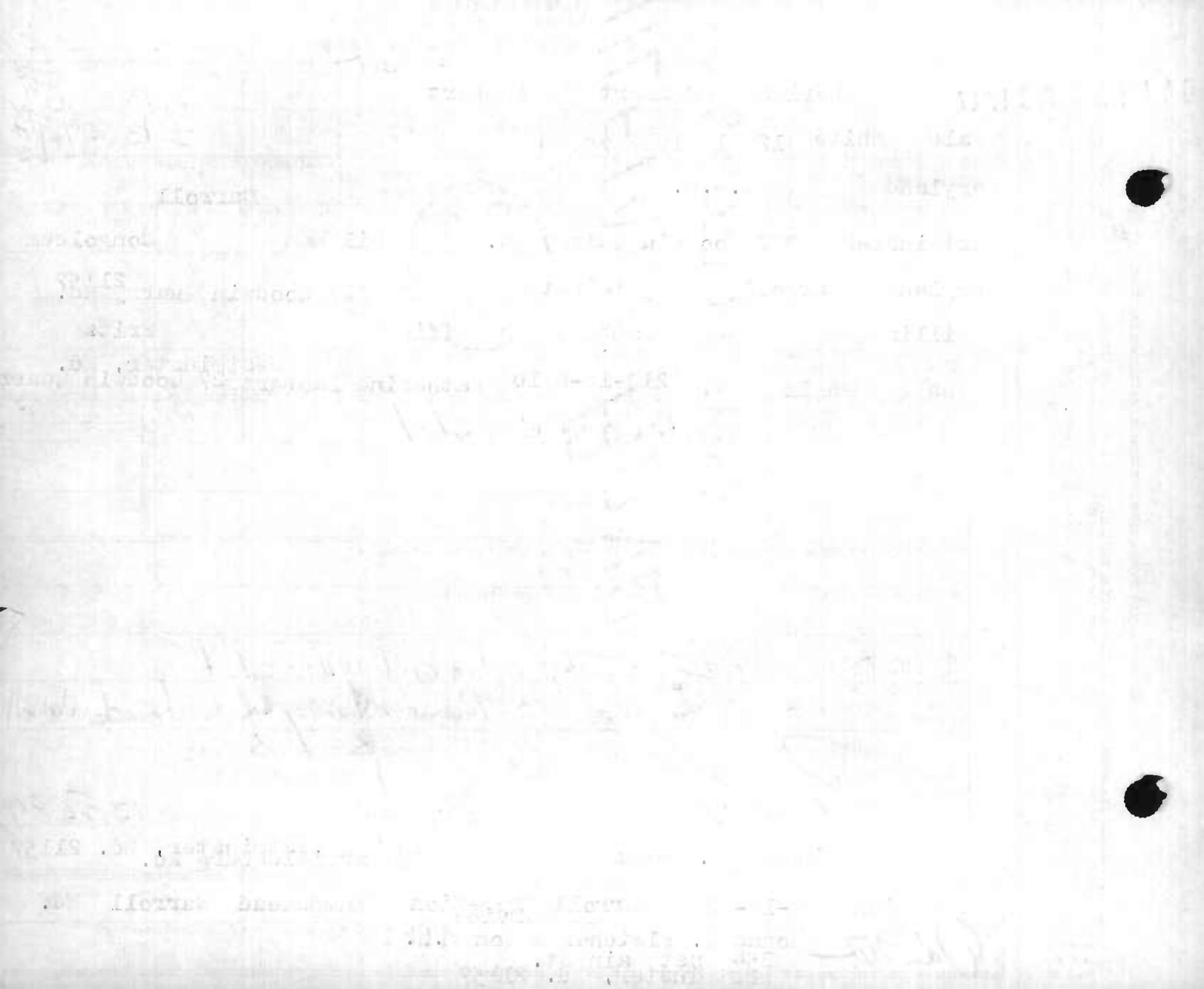
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8704921				
1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>DANA</u>	MIDDLE	LAST <u>Kyker</u>	2a DATE OF DEATH MONTH DAY YEAR <u>2-9-87</u>	MONTH <u>2</u>	DAY <u>9</u>	YEAR <u>87</u>	2b HOUR <u>2030M</u>				
3. SEX <u>M</u>	4 RACE <u>W</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>5 3 27</u>	6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <u>59</u>	7. IF UNDER 1 YEAR MONTHS DAYS YRS.		8. IF UNDER 24 HRS HOURS MIN.								
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <u>Carroll County</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll</u>											
10. CITY OR TOWN OF DEATH <u>Westminster</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carroll County General</u>			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <u>Rotary Dell Miller</u>										
12b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>														
13. USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION 13a. STATE <u>Maryland</u>			13b. COUNTY <u>Carroll</u>	13c. CITY OR TOWN <u>Westminster</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <u>19 Washington Lane</u>								
14. FATHER'S NAME FIRST <u>Dana</u>	MIDDLE <u>Hanson</u>	LAST <u>Kyke</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Grace</u>	MIDDLE	LAST <u>Brown</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>yes</u>	16b. SOCIAL SECURITY NO. (IF UNKNOWN, GIVE ALT. IDENTITIES) <u>ABII 26-18-1418</u>	17. INFORMANT <u>Dana Kyke Jr. II.</u>	ADDRESS <u>2103 Watson Dr. Westminster Md. 21157</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Invictus</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial infarction</u>						4 hours					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>an abscessed tooth</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>2-8-87</u> to <u>2-9-87</u> , that (I) (we) last saw the deceased alive on <u>2-9-87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.											22c. DATE SIGNED <u>2-9-87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Chirachet Dunagan, MD</u>		22e. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>2/11/87</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Meadow Branch</u>		23d. LOCATION STREET <u>700A Pode Rd</u>		CITY OR TOWN <u>Westminster</u>		COUNTY <u>Carroll</u>		STATE <u>Md.</u>		
24. FUNERAL DIRECTOR <u>Fletcher F.H. Fletcher</u>		ADDRESS <u>Westminster Maryland</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 13 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Seidler-Bundes</u>								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 04922		
1- STATE REGISTRAR			LAST Lambert							2a. DATE KNOWN OF ESTI- DEATH MATED		
1. DECEASED NAME (TYPE OR PRINT) 787 Charles Herbert Lambert			MIDDLE			IF UNDER 1 YR. IF UNDER 24 HRS				MONTH DAY YEAR		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 12 7 1911		6. AGE (IN YEARS LAST BIRTHDAY) 75 yrs.		MONTHS DAYS HOURS MIN.	2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 13 1987	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll		
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 327 Goodwin Quarry Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Oil Man			12b. KIND OF BUSINESS OR INDUSTRY Congoleum			
13a. STATE Maryland			13b. COUNTY Carroll			13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 327 Goodwin Quarry Rd. 21157		
14. FATHER'S NAME William			15. MOTHER'S MAIDEN NAME Effie									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WW II			16b. SOCIAL SECURITY NO. 213-16-0310			17. INFORMANT Katherine Lambert			ADDRESS Westminster, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intraoral Gunshot</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) starting the <u>underlying cause lost</u> . (b) _____ (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5 42 13 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Intraoral Gun shot</i>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>			21f. LOCATION <i>327 Goodwin Quarry Rd, Westminster Carroll</i>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Injury <input type="checkbox"/> death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <i>Richard A. Jones</i> ACTUAL SIGNATURE										and in my opinion TITLE (SPECIFY) M.D. <i>Douglas</i> MEDICAL EXAMINER DATE SIGNED <i>13 Feb 87</i>		
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones MD			ADDRESS <i>425 Warfieldsburg Rd. Westminster, Md. 21157</i>									
23a. BURIAL, CREMATION, REMOVAL <i>Cremation</i>			23b. DATE 2-16-87			23c. NAME OF CEMETERY OR CREMATORIAL SERVICE <i>Carroll Cremation Service</i>			23d. LOCATION CITY OR TOWN <i>Hampstead</i> COUNTY <i>Carroll</i> Md.			
24. FUNERAL DIRECTOR NAME <i>Thomas Fletcher</i>			ADDRESS <i>Fletcher & Son F. 851</i>			DATE REC'D. BY REGISTRAR <i>7 1987</i>			25b. REGISTRAR'S SIGNATURE			
DHMH-17 (VRA15 ME (5)) 15M 2/80												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WASHINGTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL.

MEDICAL CERTIFICATION

1 -
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7 0 4 9 2 0

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR 2d AM PM
SEK 07	RACE MALE	5. DATE OF BIRTH MONTH DAY YEAR 3 24 1897 89	6. AGE IN YEARS LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR 2d AM PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL				
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO GEN HOSP				12a. USUAL OCCUPATION (TYPE OF WORK) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13. STATE MARYLAND		13b. COUNTY CARROLL	13c. CITY OR TOWN FIN HSBURG	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2201 OLD WESTMINSTER PIKE 2848				
14. FATHER'S NAME FIRST Albert		MIDDLE Josiah	LAST Leedy	15. MOTHER'S MAIDEN NAME FIRST Sarah		MIDDLE Caroline	LAST Umberger			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-12-1622		17. INFORMANT Cloyd K. Leedy Sr.		ADDRESS 9 Morris Way Rd Owings Mills, Md. 21111				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH — 10 YEARS				
DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIO-CEREBRAL VAS. (SEVERE)						DUE TO, OR AS A CONSEQUENCE OF DISEASE				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). ABOVE KNEE AMPUTATION LEFT LEG										
19a. DATE OF OPERATION 2/17/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? GANGRENE LEFT LEG (ASCVD)				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Daniel I. Welliver</i>		TITLE (SPECIFY) M.D. AST. DEP.				DATE SIGNED 2/10/07				
EXAMINER'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER M.D.		ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 20, 1987		23c. NAME OF CEMETERY OR CREMATORIUM Evergreen Mem. Gardens		23d. LOCATION CITY OR TOWN Finksburg, Carroll, Md.		COUNTY	STATE	
24. FUNERAL DIRECTOR Eckhardt Funeral Chapel Owings Mills, Md. 21117		25a. DATE REC'D. BY REGISTRAR FEB 20 1987		25b. REGISTRAR'S SIGNATURE David R. Rendall						
BP _____ 25M _____		DHMH - 17 (VR A15 ME (5))								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then attach pages 4 and 5 to the burial permit. The burial permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or death from a traumatic event, no medical examiner may be present at the time of death.

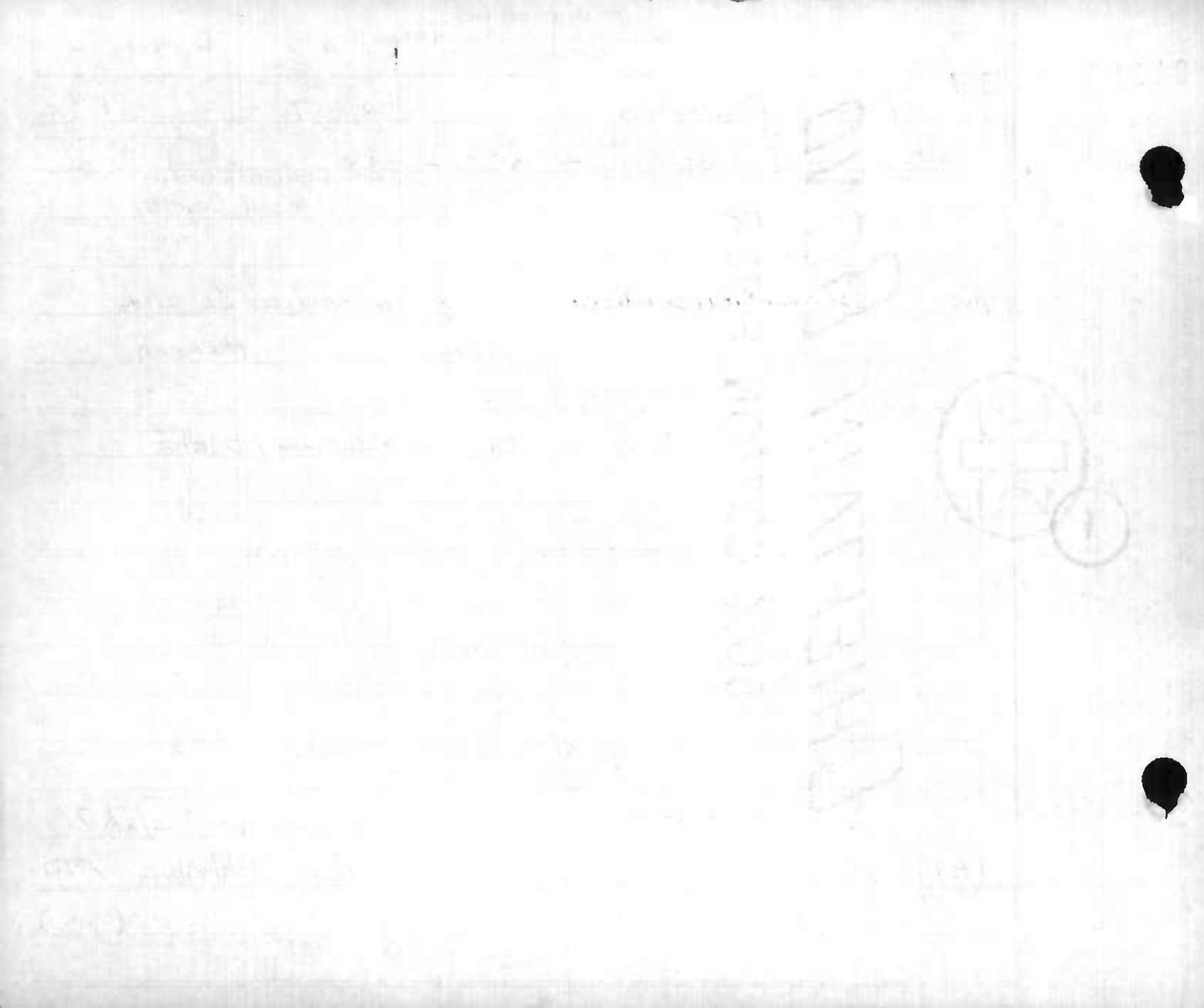
MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 04924

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	REG. NO.		
Peter Frederick Long						2/8/87						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		2b. HOUR 1:30 AM		
Male		Caucasian		2-25-02		86						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Pennsylvania		USA				Carroll County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Sykesville		FAIRHAVEN 7200 Third Avenue		Dispatcher		Trucking						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Md.		Anne Arundel		Severna Park		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1415 Andrews Rd 21146				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Milton		C.		Long	Mary						Heckman	
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		6b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORIGIN) Between WWI		16. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
YES		194-07-8734		Frederick M. Long		Severna Park, MD 21146						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE												
DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 31, 1982, to 2/8, 1987, that (I) (we) last saw the deceased alive on 2/8, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Ellis Mez MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/8/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ellis Mez		22e. ADDRESS 1425 Liberty Road Eldersburg, MD										
23a. BURIAL, CREMATION, REMOVAL BY BURIAL		23b. DATE 02-11-87		23c. NAME OF CEMETERY OR CREMATORIAL Grandevue Cemetery		23d. LOCATION CITY OR TOWN S. Whitehall Township (Lehigh) PA						
24. FUNERAL DIRECTOR NAME Haight Funeral Home		ADDRESS Sykesville, MD		25a. DATE REC'D. BY REGISTRAR FEB 9 1987		25b. REGISTRAR'S SIGNATURE						



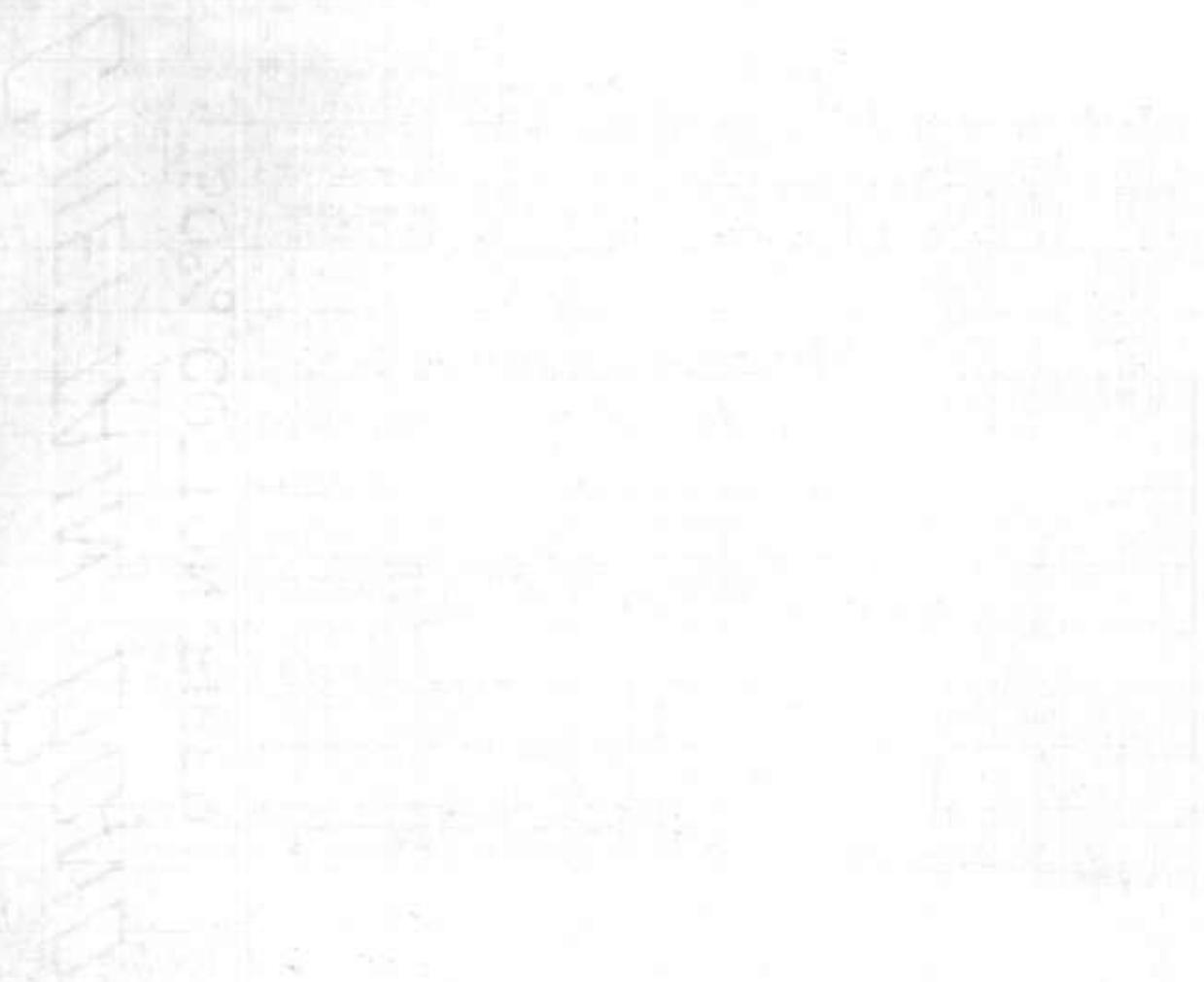
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having shown any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8704925		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Herbert E. Lovell, Jr.						2			1	87	2015pm			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
M ale		W hite		MONTH	DAY	YEAR	62			MONTHS	DAYS	HOURS	MIN.	
8 8 24		YRS.												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		U.S.A.					Carroll County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Westminster		Carroll County Gen. Hosp.					waterfront dock worker dock worker							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		105 Schoolhouse Road 21784			
MD		Carroll		Gaithersburg										
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST		ADDRESS				
		Herbert	E.	Lovell, Sr.	FIRST Emma			L.		Yingling				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		220-14-3026		Margaret H. Lovell			cardio respiratory arrest							
							(b) Respiratory Failure							
				(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Acute myocardial infarction														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2-1-18</u> to <u>2-1-87</u> , that (I) (we) last saw the deceased alive on <u>2-1-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>2-1-87</u>		
22b. SIGNATURE <u>Chitrachedu McAnna</u>		DEGREE		ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHITRACHEDU McANNA</u>		22e. ADDRESS <u>700 1/2 pole Rd. Westminster 21157</u>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 02-05-87			23c. NAME OF CEMETERY OR CREMATORIAL PIPE CREEK CEMETERY			23d. LOCATION CITY OR TOWN NEW WINDSOR CARROLL MD	
24. FUNERAL DIRECTOR NAME <u>HAIGHT FUNERAL HOME</u>		ADDRESS <u>SYKESVILLE, MD</u>		25a. DATE REC'D. BY REGISTRAR FEB 4 1987			25b. REGISTRAR'S SIGNATURE <u>J. Anderson-Lindalee</u>							

100-100-1040



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please return to the physician. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Harmless", then all other injuries, or other traumatic events, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8704920					
1 - FOR STATE REGISTRAR			I. DECEASED NAME LOUISA B. McBee			LAST			2a. DATE OF DEATH 2 4 87	MONTH	DAY	YEAR	2b. HOUR 11:40pm				
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 27, 1895			6. AGE (IN YEARS LAST BIRTHDAY) 91			IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll									
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant View Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Practical Nurse			12b. KIND OF BUSINESS OR INDUSTRY MD						
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 25905 Long Corner Rd. 20879									
14. FATHER'S NAME FIRST Levi		MIDDLE B.		LAST Taylor		15. MOTHER'S MAIDEN NAME FIRST Bertha			MIDDLE Ann		LAST Fansler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-24-0520			17. INFORMANT Bertha Stanley, Item 13			ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cardiac arrhythmia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min					
DUE TO, OR AS A CONSEQUENCE OF (b) Catherosclerotic coronary disease												Yrs					
DUE TO, OR AS A CONSEQUENCE OF (c) General Atherosclerosis												Yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Sen Alzheimer's, Depression																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12/18 , 19 85 , to 2/9 , 19 87 , that (I) (we) last saw the deceased alive on 1/21/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																	
22b. SIGNATURE Melvin Kardon		DEGREE (u)		ATTENDING PHYSICIAN Melvin Kardon		MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/10/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin Kardon MD		22e. ADDRESS 2000 Century Plaza MD 21042															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 9, 1987		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore National			23d. LOCATION CITY OR TOWN Baltimore, Maryland			CITY OR TOWN		COUNTY	STATE				
24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.		25a. DATE REC'D. BY REGISTRAR FEB 9 1987		25b. REGISTRAR'S SIGNATURE His Office													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page will be forwarded to the State Dept. of Health and Mental Hygiene prior to mailing.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or condition which may affect the medical examiner's ability to determine cause of death, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8704921					
1 - STATE REGISTRAR 1 DECEASED NAME (TYPE OR PRINT)			FIRST MAURICE ERNEST MEUNIER			LAST			2a DATE OF DEATH February 23, 1987	MONTH	DAY	YEAR	2b HOUR 1:00 A.M.		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH July 19, 1908			6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co.			MD.					
10 CITY OR TOWN OF DEATH Taneytown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4020 Bullfrog Road		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stonemason			12b KIND OF BUSINESS OR INDUSTRY Building								
13a STATE Maryland		13b COUNTY Carroll		13c CITY OR TOWN Taneytown			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 4020 Bullfrog Rd./21787					
14 FATHER'S NAME FIRST William		MIDDLE E.		LAST Meunier			15 MOTHER'S MAIDEN NAME Marie			FIRST		MIDDLE		LAST Pépin	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) No		17 INFORMANT Blanche Meunier			4020 Bullfrog Rd. Taneytown, MD 21787								
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA, PRIMARY UNKNOWN</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) _____															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____										
22a. I certify that (I) (this hospital) attended the deceased from <u>11/7</u> , 19 <u>87</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>2/9</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														22c. DATE SIGNED <u>2-23-87</u>	
22d. SIGNATURE <u>Ronald Krablin, M.D.</u>		22e. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ronald Krablin, M.D.</u>		22e. ADDRESS <u>455 S. Washington St. Gettysburg, PA</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/26/87		23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph Cemetery			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____								
24 FUNERAL DIRECTOR NAME 138 E. Baltimore St. Skiles Funeral Homes		ADDRESS Taneytown, MD 21787			25a. DATE REC'D. BY REGISTRAR MAR 02 1987 Julie Benson-Burke										

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10 HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

11 FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81 04928															
1 - STATE REGISTRAR			2a DATE OF DEATH 2-8-87							2b HOUR 3A M															
2. DECEASED NAME, FIRST MIDDLE LAST			3. SEX FEMALE							4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH FEB 21 1895			6. AGE IN YEARS LAST BIRTHDAY 91			7. BIRTHPLACE STATE OR FOREIGN COUNTRY CARROLL		8. CITIZEN OF WHAT COUNTRY? U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL CO MD.		
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTMINSTER NURSING CENTER							12a USUAL OCCUPATION HOUSEWIFE			12b KIND OF BUSINESS OR INDUSTRY DOMESTIC												
13a STATE MARYLAND			13b COUNTY CARROLL			13c CITY OR TOWN WESTMINSTER			13d INSIDE CITY LIMITS? YES X NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 335 FAIR AVE 21157													
14. FATHER'S NAME SIMON			15. MOTHER'S MAIDEN NAME SUSAN HOSFIELD																						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO			16b SOCIAL SECURITY NO. 213-05-1559							17. INFORMANT MRS. LOUISE S. SYDNER			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
18. CAUSE OF DEATH Enter only one cause per line for 18, 19, and 20. PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest																									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CVA																									
DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia																									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. NA																									
19a DATE OF OPERATION NA			19b CONDITION FOR WHICH OPERATION WAS PERFORMED NA							20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) NA			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) NA																			
21d INJURY OCCURRED WHILE AT WORK NA			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA			21f LOCATION STREET NA			CITY OR TOWN		COUNTY		STATE												
22a I certify that (at this hospital) attended the deceased from 21/7 1987 to 21/8 1987, that (s/he) lost the deceased alive on 21/7 1987 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) did/did not view the body after death.																									
22b SIGNATURE John W. Middleton			22c DEGREE							ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 2/8/87												
22e PHYSICIAN'S NAME (TYPE OR PRINT) John W. Middleton			22f ADDRESS 6256 Buet Blvd Westminster MD 21157																						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE FEB 11, 1987			23c NAME OF CEMETERY OR CREMATORIAL MEADOW BRANCH CEM.			23d LOCATION CITY OR TOWN WESTMINSTER CARROLL MT.			23e COUNTY STATE													
24 FUNERAL DIRECTOR NAME Robert & Nyerd			ADDRESS 91 Wicks St. 21157			25a DATE REC'D. BY REGISTRAR FEB 9 1987			25b REGISTRAR'S SIGNATURE Julia L. Landers																

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 / 04929		
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 2 - 1 - 87							2b. HOUR 2:40 PM		
1. DECEASED NAME (TYPE OR PRINT) <i>Gerhard Mowinckel</i>			MIDDLE			LAST						
3. SEX Male		4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 01-19- 1899			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant View Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4101-Balt. Nat. Pk. - 2177				
14. FATHER'S NAME Andrew		15. MOTHER'S MAIDEN NAME Mowinckel Julia										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-52-3425			17. INFORMANT Mr. Andrew Mowinckel			ADDRESS Baltimore, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic lung disease</i> Pneumonia										days		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic lung disease</i>										yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Mental retardation, Alzheimer's disease</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1/2/82</i> , 1982, to <i>2/1</i> , 1987, the (I) (we) last saw the deceased alive on <i>1/29</i> , 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I) (we) did not view the body after death.												
22b. SIGNATURE <i>Reed K. Kudewitz</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>2/2/87</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Reed K. Kudewitz</i>		22e. ADDRESS <i>2000 Century Plaza</i>			22f. ADDRESS <i>Columbia</i>			22g. ADDRESS <i>MD 21026</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 02-03-87		23c. NAME OF CEMETERY OR CREMATORIUM SPRINGFIELD CEMETERY			23d. LOCATION CITY OR TOWN SYKESVILLE		COUNTY CARROLL		STATE MD	
24. FUNERAL DIRECTOR NAME <i>HAIGHT FUNERAL HOME</i>		ADDRESS <i>SYKESVILLE, MD</i>			25a. DATE REC'D. BY REGISTRAR <i>FEB 4 1987</i>			25b. REGISTRAR'S SIGNATURE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 0 4 9 3 0

1. DECEASED NAME (TYPE OR PRINT)		FIRST ADA	MIDDLE May	LAST NICKLES	2d. DATE OF DEATH MONTH DAY YEAR 2 26 87	MONTH DAY YEAR 1555 P.M.	2d HOUR 1555 P.M.
3. SEX Female		4. RACE White		S. DATE OF BIRTH MONTH DAY YEAR 2 2 1904	6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll		
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Finksburg				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2063 Baltimore Blvd. 21048	
14. FATHER'S NAME FIRST Harry		MIDDLE 	LAST Poole	15. MOTHER'S MAIDEN NAME FIRST Myra		MIDDLE Eugene	LAST Forney
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-22-8879		16c. ADDRESS 167 Manchester Rd. Herbert G. Nickles Westminster, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>intractable congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic myocardopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic heart disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>atrial fibrillation, hypertension, hemithorax</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21e. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> , 19 <u>87</u> , to <u>2/26</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>2/26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dale Espenschade MD</u>		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Park Espenschade W. Jr. MD		22e. ADDRESS 419 Malcolm Dr. Westminster, Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		23b. DATE 3-2-86	23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		23d. LOCATION CITY OR TOWN Finksburg	COUNTY Carroll	STATE Maryland
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.D.P.		24a. ADDRESS 214 East Main Street	24b. STATE REC'D. BY REGISTRAR Westminster, Md. 21157		24c. REGISTRAR'S SIGNATURE MAR 02 1987		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove item 21d and attach it to the burial permit. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal or other traumatic event. The medical examiner may be notified if item 18 shows any injury, or other traumatic event.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
EDWARD			L.		O'CONNOR	27			27	87	732	AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		WHITE		MONTH	DAY	YEAR	69			MONTHS	DAYS	HOURS	MIN.	
4. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U. S. A.						CARROLL COUNTY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
WESTMINSTER		CARROLL COUNTY GENERAL Hospt			Service Repairman			Office Equip.						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MARYLAND		CARROLL		SYKESVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4406 BARTHOLOMEW RD. 21784					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
Edward		Joseph	O'Connor	Grace				Sorgler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS		
YES				212-18-7758				ELIZABETH O'CONNOR				SAME		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACRANIAL HEMORRHAGIC INFART ONE DAY</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE CRISIS</u>												ONE DAY		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>SISTEMIC HYPERTENSION MANY YEARS</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/6</u> , 19 <u>87</u> , to <u>2/7</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>2/6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>CRISTIAND ALBA</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2/7/87</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CRISTIAND ALBA, MD.</u>			22e. ADDRESS <u>19 Ridge Rd, WESTMINSTER MD 21157</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 02-11-87			23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL			23d. LOCATION CITY OR TOWN WASHINGTON, D.C.			STATE		
BURIAL														
24. FUNERAL DIRECTOR HAIGHT FUNERAL HOME			25a. DATE REC'D. BY REGISTRAR FEB 9 1987						25b. REGISTRAR'S SIGNATURE					
SYKESVILLE, MD														

043523 FEB 10 FOR STATE REGISTRAR

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Page 1 and page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, Bureau of Vital Statistics, 100 North Wolfe Street, Baltimore, Maryland 21201.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, illness, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
8 / REG. NO. 0 4 9 3 2														
1 - STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR					
Roy			Renfro			Feb. 11, 1987			2b. HOUR 9:00am					
3. SEX Male			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR Oct. 13, 1909			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County					
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME OF FACILITY, GIVE STREET ADDRESS) 2731 Manchester Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic			12b. KIND OF BUSINESS OR INDUSTRY Machine					
13a. STATE Md.			13b. COUNTY Carroll			13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2731 Manchester Rd. 21157		
14. FATHER'S NAME FIRST MIDDLE LAST Dock Renfro			15. MOTHER'S MAIDEN NAME Lilly Beam											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-16-0377			17. INFORMANT Mrs. Cleo Renfro			ADDRESS 2731 Manchester Rd. Westminster, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days														
DOUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Lymphocytic Lymphoma</u> 2 years														
DOUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19, 86</u> , to <u>Feb. 11, 1987</u> , that (I) (we) last saw the deceased alive on <u>Feb. 10, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Steven J. Shaffer</u>			22c. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2/11/87					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Steven J. Shaffer			22f. ADDRESS 4519 Lower Beckleysville Rd Hampstead Ald.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 14, 1987 Kirkridge Cem.			23c. NAME OF CEMETERY OR CREMATORIAL Hampstead, Carroll, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME V.J. Echhardt			25a. DATE REC'D. BY REGISTRAR FEB 13 1987			25b. REGISTRAR'S SIGNATURE J. M. J. Echhardt								
DHMH - 16 50M 4/83 (VRA 15, 4)														

1

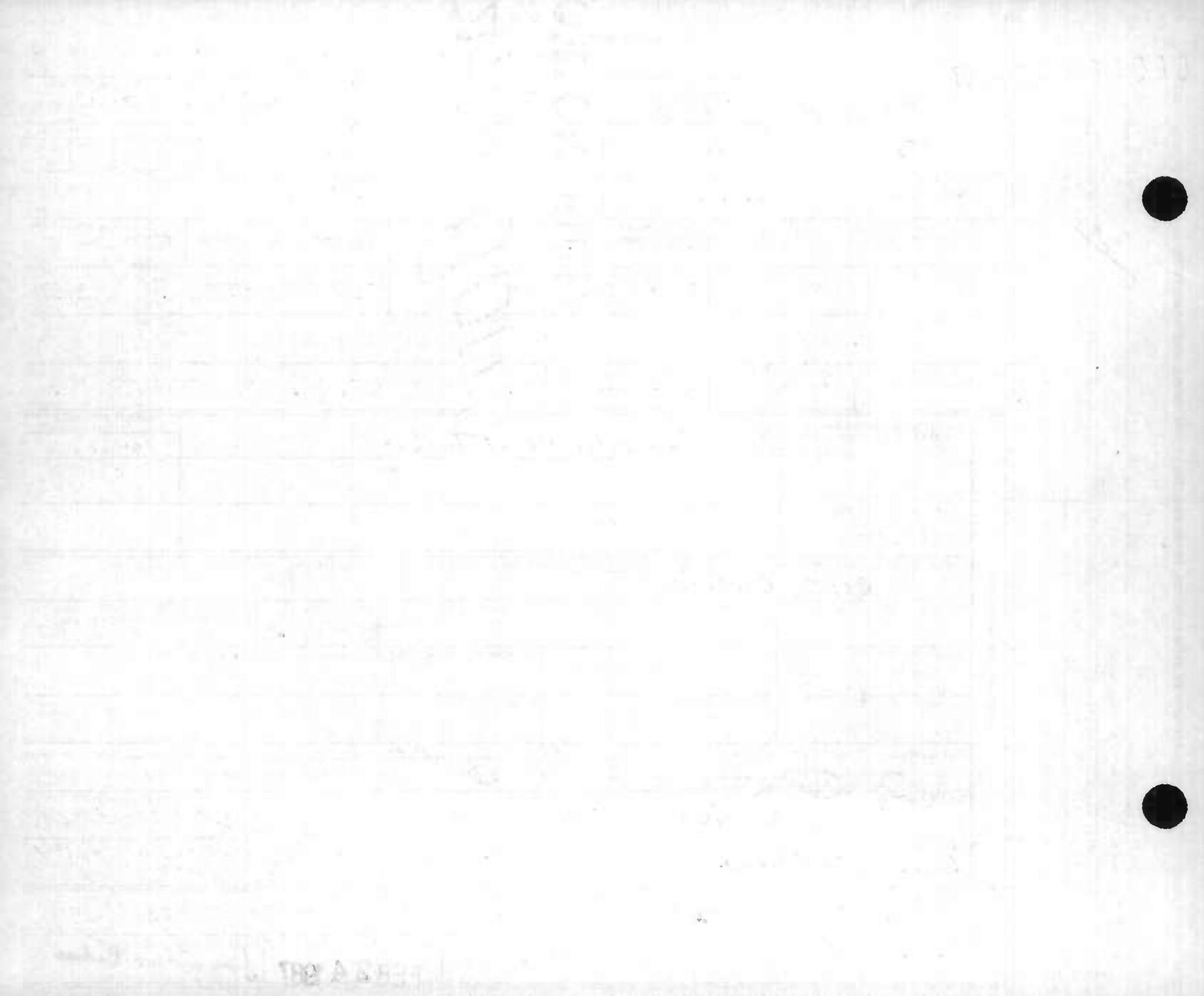
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked item 18, any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 / 0 4 9 3 3	
										REG. NO.	
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
		MARGARET DOUGLAS RICE						02/21/87 87		1:30PM M	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		MO/01/23/16		71		MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.			
NEW YORK		U.S.A.				CARROLL					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a USUAL OCCUPATION		12b KIND OF BUSINESS OR INDUSTRY FOR WHICH WORKING LIFE					
WESTMINSTER		1250 UNIONTOWN RD.		HOUSE WIFE		OWN HOME					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE MD		13b CITY CARROLL		13c TOWN WESTMINSTER		13d OUTSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 1250 UNIONTOWN RD.		ZIP CODE 21157	
14. FATHER'S NAME		LAST		15. MOTHER'S MAIDEN NAME		ADDRESS					
WALTER M. WOLFE				MARY MACNAUGHTAN		LAST					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO NO OR UNKNOWN		16b SOCIAL SECURITY NO. 217-50-6329		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
				G. HERBERT RICE, JR.		1230 UNIONTOWN RD.		1 year.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>COPD, Cirrhosis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1986</i> , to <i>1986</i> , that (I) (we) last saw the deceased alive on <i>1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Norman Goldstein</i>		22c. DEGREE <i>M.D.</i>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED <i>2/21/87</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Norman Goldstein</i>		22e. ADDRESS <i>218 Washington Street, Hampstead, Carroll 21157</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 02/22/87		23c. NAME OF CEMETERY OR CREMATORIUM CARROLL CREMATION		23d. LOCATION HAMPSTEAD CARROLL		MD/ATE			
24. FUNERAL DIRECTOR NAME D. HARTZLER		25a. DATE REC'D. BY REGISTRAR FEB 24 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Dawson-Landale</i>							
BP _____		DHMH - 16 60M 7/84 (VRA 15, 4)									



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3704234
REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR												
Margaret RION							2 14 87				3:45 P.M.												
3. SEX FEMALE				4. RACE W		5. DATE OF BIRTH MONTH 3 DAY 8 YEAR 1916		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md				7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY				10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Glykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 21784				14. FATHER'S NAME FIRST James		15. MOTHER'S MAIDEN NAME FIRST Knauff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. n/a		17. INFORMANT Gary Rion				ADDRESS 21093				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SMALL CELL CARCINOMA OF LUNG		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b)				DUE TO, OR AS A CONSEQUENCE OF				(c)											
DUE TO, OR AS A CONSEQUENCE OF																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												ACUTE MYOCARDIAL INFARCTION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
								YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTARY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Arthur L. Rudo, MD												DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2/14/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR L. RUDO, MD				22e. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER, MARYLAND 21157				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation				23b. DATE 2/16/87		23c. NAME OF CEMETERY OR CREMATORIAL Carroll Cremation		23d. LOCATION CITY OR TOWN Hampstead		COUNTY		STATE			
24. FUNERAL DIRECTOR PITT'S FUNERAL HOME												25a. DATE OF DEATH ADMITTED FEB 24 1987				25b. DATE OF INTERMENT 412 Washington rd							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then place in the burial permit. Then place in the Burial and Mental Hygiene permit for burial, removal, or cremation.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other significant event, the medical examiner must be informed at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Nellie May Rosier					Rosier	Feb. 19, 1987				0800 AM		
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS		
Female			White	9-1-1893			93			MONTHS DAYS	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.			U.S.A.						Carroll			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Gaithersburg			7721 Gaither Rd.			Homemaker			Home			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS, ZIP CODE	21735			
Md.			Carroll	Gaithersburg				7721 Gaither Rd				
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST			
Joshua				Hanna	Ivy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			
No			220 18 0378			George Rosier - Gaither Md.						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a) Cardiac Bradycardia/rhythmia / Arrest												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD												
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from July 14, 1986, to Feb 19, 1987, that (1) we last saw the deceased alive on Feb 3, 1987, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (1) we did not view the body after death.												
22b. SIGNATURE James L. Forsberg												
DEGREE												
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22c. DATE SIGNED 2-19-87												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS JAMES L. FORSBERG, MD Po Box 1229, Sykesville, MD 21784									
23a. FUNERAL CREMATION, REMOVAL			23b. DATE 2-21-87			23c. NAME OF CEMETERY OR CREMATORIAL Lakeview Cemetery			23d. LOCATION CITY OR TOWN Sykesville COUNTY Carroll STATE Md.			
24. FUNERAL DIRECTOR NAME Harry W. Hight			ADDRESS Sykesville, Md.			25a. DATE REC'D. BY REGISTRAR FEB 23 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			
DHMH - 16 60M 7/84 (VRA 15, 4)												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 2, AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1A, 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 04930		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI. DEATH MATED			2b. HOUR MONTH DAY YEAR					
MARY KUHNS LOYER						<input type="checkbox"/> 2-5 '87 10P								
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH DAY YEAR	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE	12b. KIND OF BUSINESS OR INDUSTRY				
FEMALE	WHITE	FEB 9 1901 85 yrs.		MONTHS DAYS HOURS MIN		2-6 1987 220 PM		WESTMINSTER 1008 HIGH ST. SHOP RD	clerk	Dept				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY						
WESTMINSTER		WESTMINSTER 1008 HIGH ST. SHOP RD												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		14d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14e. STREET ADDRESS		14f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
MD		CARROLL		WESTMINSTER		NO		1008 HIGH ST. SHOP RD		5 YEARS				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
Thomas				Kuhns		Alice				Rhodes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
no			n/a			214-16-1490A Joan Hollinger			21157 25 Fitzhugh Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION -														
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. <i>Daniel J. Welliver</i> <i>MD ABP DPM</i>										DATE SIGNED <i>2-6-87</i>		
EXAMINER'S NAME (TYPE OR PRINT)		MEDICAL EXAMINER <i>2-18 WESTMINSTER HEIGHTS</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS						23d. LOCATION CITY OR TOWN		COUNTY	STATE	
burial		2/9/87		Meadow Branch						Westminster Carroll Md				
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE												
PRITTS FUNERAL CHAPLERS		FEB 13 1987 <i>Jane Barber</i>												

430-1000000 1000 81 833

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If item 21 is marked as "show any injury, or other traumatic event, the medical examiner should be notified."

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8704931 REG. NO.
1. DECEASED NAME <i>(Type or Print)</i> MARGARET M SAUER			2a DATE OF DEATH FEBRUARY 24, 1987	MONTH YEAR	DAY	2b HOUR 1:45 A.M.
3 SEX Female	4 RACE White	5. DATE OF BIRTH 1-1-1914	6 AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co.			
10 CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hosp.	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Secretary				12b KIND OF BUSINESS OR INDUSTRY Engineering
13a STATE Md.	13b COUNTY Carroll	13c CITY OR TOWN Westminster	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 705 Riley Ct. 21157		
14. FATHER'S NAME FIRST Valentine	MIDDLE	LAST Schoenig	15. MOTHER'S MAIDEN NAME Mary	16. ADDRESS O'Donnell		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. 337-07-8753	17. INFORMANT Steven A. Sauer, Same as 13e	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>METASTATIC CARCINOMA UNKNOWN PRIMARY</i>						
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>DIABETES PSEUDOPHENIC JAWAVUE DISEASE</i>						
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from 214 . 19 87 to 2124 . 19 87 , that (I) (we) did (did not) view the body after death, now deceased alive on 2123 . 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.						
22b SIGNATURE <i>Howard S. Johnson MD</i>			DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22d PHYSICIAN'S NAME (TYPE OR PRINT) Howard S. Johnson, MD			22e DATE SIGNED 2/24/87	22e ADDRESS 215 Washington Mills Medical Center		
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b DATE 2-27-87	23c NAME OF CEMETERY OR CREMATORIAL Parkwood	23d LOCATION CITY OR TOWN Balto., Md.	COUNTY	STATE	
24 FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Harford Rd.						
ADDRESS FEB 25 1987 Julia Sander						
REG. NO. BY REGISTRAR 25b REGISTRAR'S SIGNATURE						

TRINITY

11 March 10

1988

11 March 10

1988

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 3 should be filed in by the funeral director, page 3 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8704938	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			7a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Louise Beacham Senseney						2-25-87			1030 P.M.				
3. SEX Female.		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS			# UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE COUNTRY Avondale, Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD						
10. CITY OR TOWN OF DEATH Manchester.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Enriquev Neg. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY None						
13a. STATE Md		13b. COUNTY Carroll		13c. CITY OR TOWN Manchester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3332 Main St. 21102			
14. FATHER'S NAME FIRST James		MIDDLE W		15. MOTHER'S MAIDEN NAME FIRST Nellie			MIDDLE Shinghuff						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-10-7000		17. INFORMANT Fred Senseney			ADDRESS 146 Willis St. 21157						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Remote CVAs, Dementia, UTI, Arthritis, Malnutrition													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from 2/18, 1987, to 2/25, 1987, that (1) we last saw the deceased alive on 2/18, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we (did) did not view the body after death.													
22b. SIGNATURE James L. Forsberg, MD												22c. DATE SIGNED 2-25-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James L. Forsberg, MD		22e. ADDRESS 3007 Bachman Rd. Manchester Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 3/1/87		23c. NAME OF CEMETERY OR CREMATORIAL Pipe Creek			23d. LOCATION CITY OR TOWN Linwood			COUNTY STATE Carroll, MD			
24. FUNERAL DIRECTOR NAME PRITTS FUNERAL HOME		412 Washington Rd. WESTMINSTER, MD			25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE MAR 05 1987 John Pritts, Jr.								

18-22-4

5000 ft. above sea level.

Windward

80 30 RAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 struck through, injury, or other traumatic event, Item 18 should be marked as

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8704939
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>GEORGE</i>	MIDDLE <i>NELSON</i>	LAST <i>SHOWER</i>	2a DATE OF DEATH	MONTH FEB	DAY 9	YEAR 87	2b HOUR 9:30 A.M.
3. SEX <i>MALE</i>		4. RACE <i>CAUCASIAN</i>		5. DATE OF BIRTH MONTH 4 - DAY 5 - YEAR 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS HOURS 0 MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>CARROLL COUNTY, MD.</i>				
10. CITY OR TOWN OF DEATH <i>TANEY TOWN</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2765 CROUSE MILL ROAD</i>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>MANUFACTURING</i>		12b KIND OF BUSINESS OR INDUSTRY <i>LUM BAR</i>				
13a STATE <i>MARYLAND</i>		13b COUNTY <i>CARROLL</i>		13c CITY OR TOWN <i>TANEY TOWN</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>21787 2765 CROUSE MILL ROAD</i>		
14. FATHER'S NAME FIRST <i>ROBERT</i>		MIDDLE <i>McILHENNY</i>		LAST <i>SHOWER</i>		15. MOTHER'S MAIDEN NAME FIRST <i>LAURA</i>		MIDDLE <i>KATE</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>218-30-9653</i>		17. INFORMANT <i>MARGORIE SHOWER</i>		ADDRESS <i>SAME</i>				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SUPRANUCLEAR PALSY</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>YEARS</i>
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>8/22 1979</i> to <i>2/19 1987</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>2/4 1987</i> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.										
22b. SIGNATURE <i>Wm. R. LINTHICUM, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/19/87</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm. R. LINTHICUM, M.D.</i>		22e. ADDRESS <i>TANEY TOWN, MARYLAND 21787</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Feb. 10, 87</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Carroll Cremation Serv.</i>		23d. LOCATION <i>Hampstead, Carroll Co., Md.</i>				
24. FUNERAL DIRECTOR <i>Skiles Funeral Home, Taneytown, Md. 21787</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 13 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandrea</i>						

Form 0 - Informational and Record Sheet for
Individuals

10-81-83

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other tragic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8704940	
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR 2-3-87							2b HOUR 1830 P	
1. DECEASED NAME FIRST MIDDLE LAST Alice m. Slonaker.											
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2-15-24			6. AGE IN YEARS LAST BIRTHDAY 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital		12a. USUAL OCCUPATION Seamstress			12b. KIND OF BUSINESS OR INDUSTRY Clothing				
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3928 Sunset DR. 21074		
14. FATHER'S NAME FIRST John		MIDDLE Kesner		15. MOTHER'S MAIDEN NAME Mattie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 234-48-3363		17. INFORMANT Mr. William A. Slonaker, Hampstead, Md.			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Amyotrophic lateral sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER:		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2-3-1987 to 2-3-1987, that (I) (we) lost the deceased alive on 2-3-1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did) not view the body after death.											
22b. SIGNATURE CHITRACHEDU NAGANNA MD		DEGREE		22c. DATE SIGNED 2/3/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NAGANNA		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 700A Rocke Rd Westminster MD 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-7-87		23c. NAME OF CEMETERY OR CREMATORIAL HAMPSTEAD CEMETERY		23d. LOCATION CITY OR TOWN HAMPSTEAD COUNTY CARROLL STATE MD.					
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 6 1987 Julia Sanderson-Landells							
DHMH - 16 60M 7/84 (VRA 15, 4)											

5-15-240
100-8-A 100-8-B 100-8-C
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100-8-B has 2 small white marks on the
left side of the front panel. There is also 1 small
white mark on the right side of the front panel.
100-8-C has 2 small white marks on the
left side of the front panel.

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial/transit permit. Then please remove carbon portion. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If Item 18 is marked as Item 18 shows any injury, or other traumatic event in

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 87 04941	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
<u>WILLIAM</u>			<u>F.</u>	<u>SMITH</u>		2 - 22 - 87			1800 ⁰⁰				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		04 - 16 - 1925			61 YRS			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U.S.A.					Carroll County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			21784			
Sykesville		1251 Fannie Dorsey Road		Supervisor.			Whiskey Manuf.						
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21784			
Maryland		Carroll		Sykesville			1251 Fannie Dorsey Road						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	Vogle				
William			Smith	Catherine									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
YES		WWII		219165875			Nora Smith Sykesville, MD 21784						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <u>ASCVD</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>mild renal failure</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Multiple CVA's, remote myocardial infarctions</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				<input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (1) this hospital attended the deceased from <u>January 19, 87</u> to <u>February 19, 87</u> , that (2) we last saw the deceased alive on <u>February 19, 87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) we did (did not) view the body after death.													
22c. DATE SIGNED <u>James L. Forsberg</u> <u>MD</u> <u>2-22-87</u>													
22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		22e. ADDRESS <u>(James L. FORSBERG, MD Po Box 1229 SYKESVILLE MD 21784)</u>		22f. MEDICAL DIRECTOR <input type="checkbox"/>			22g. STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 02-26-87		23c. NAME OF CEMETERY OR CREMATORIUM LAKE VIEW CEMETERY			23d. LOCATION CITY OR TOWN SYKESVILLE			COUNTY CARROLL		STATE MD	
24. FUNERAL DIRECTOR HATHT FUNERAL HOME SYKESVILLE, MD 21784													
25a. DATE REC'D. BY REGISTRAR FEB 23 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Deidra Randolph</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 7 0 4 9 4 2			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
Robert. H.					Sternier	Feb. 18. 87					1725 P		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male.			White.		Month	Day	Year	74			MONTHS	DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS			
Westminster.			Carroll.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Carroll Co.			YRS.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Westminster.			Carroll County Gen'l Hospital		Farmer								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Md			Carroll		Manchester		Yes			4850 Stoney Lane. 21102			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST				
John			W.		Sternier	Lizzie			Black				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			213-38-6678		Mrs. Robert Sternier, Manchester, Md								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Asystole / Ventricular fibrillation</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Vasculitis</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>COPD - Septicemia</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 19, 1987</i> , to <i>Feb 18, 1987</i> , that (I) (we) last saw the deceased alive on <i>Feb 18, 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>John S. Harshey, MD</i> DEGREE													
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED <i>2/18/87</i>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John S. Harshey, MD.</i>		22e. ADDRESS <i>8 Anson St. Westminster, Md. 21157</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 2-21-87		23c. NAME OF CEMETERY OR CREMATORIAL Immanuel Cemetery			23d. LOCATION CITY OR TOWN Manchester Carroll		COUNTY Md.			
24. FUNERAL DIRECTOR Eline Funeral Home, Hampstead, Md.													
25a. DATE REC'D. BY REGISTRAR <i>FEB 20 1987</i> 25b. REGISTRAR'S SIGNATURE <i>Julia Pendleton Pendleton</i>													
DHMH - 16 60M 7/84 (VRA 15, 4)													

REF ID: A6588

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal for other purposes.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 04943		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
MARY E SWAN						02	18	87	08	04	5:41 PM	
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
FEMALE			WHITE	MONTH	DAY	YEAR	83		MONTHS	DAYS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.		
WESTMINSTER			USA				Carroll County			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
WESTMINSTER			CARROLL COUNTY GENERAL HOSPITAL									
13a. STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS ZIP CODE			
MD			Carroll	Hampstead		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1217 N Carroll ST Hampstead MD 21074			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	Nash		
Harry			Morris	Harris	Mary			Ella				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS				
NO			214-30-1653		Mrs. M. Pauline Lang, Hampstead, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) CARDIOPULMONIC SHOCK										ACUTE		
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION										CHRONIC		
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) AORTIC SEPTUM DEFECT												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (1) (his/her) attended the deceased from 21/01/87, 19 to 21/02, 19, that (1) (we) last saw the deceased alive on 21/02, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 2/18/87		
22b. SIGNATURE Howard G. Lawrence, MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard G. Lawrence, MD			22e. ADDRESS 215 WASHINGTON STS WESTMINSTER 21087									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-21-87		23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Mem. Gard.			23d. LOCATION CITY OR TOWN Finksburg			COUNTY Carroll	STATE Md.
24. FUNERAL DIRECTOR Eline Funeral Home, Hampstead, Md.			25a. DATE REC'D. BY REGISTRAR FEB 20 1987							25b. REGISTRAR'S SIGNATURE Howard G. Lawrence		
ADDRESS												

480 030 631

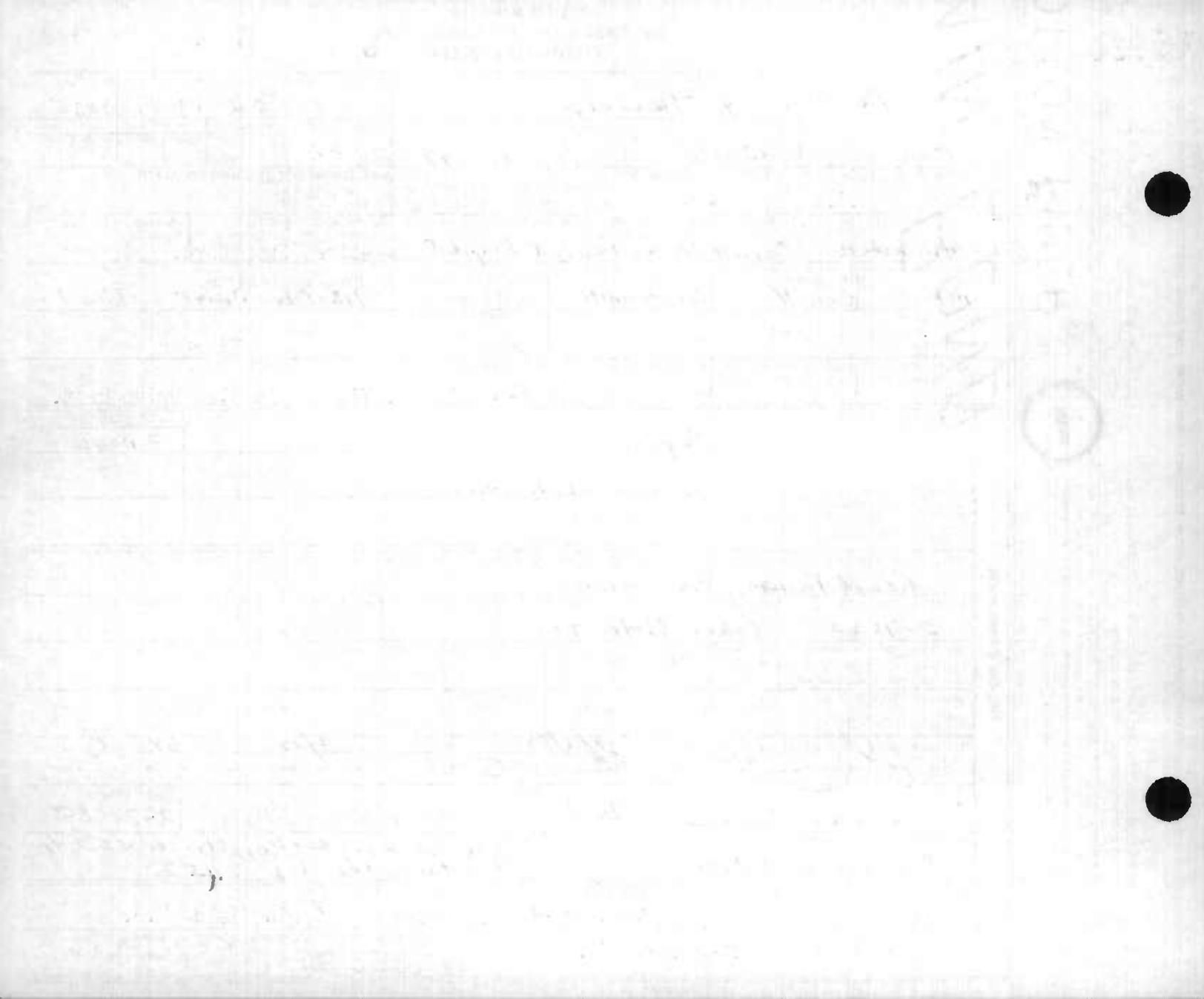
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon imprint. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma resulting in death, medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 0444		
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Herbert A. Tiemann</i>	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
3. SEX <i>Male</i>		4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>11 12 99</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Elizabeth, N.J.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i>	MD.		
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Exon Corp.</i>		
13a. STATE <i>Md.</i>		13b. COUNTY <i>Carroll</i>	13c. CITY OR TOWN <i>Westminster</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>715 Glen Drive 21157</i>		
14. FATHER'S NAME FIRST <i>Otto</i>		MIDDLE <i></i>	LAST <i>Tiemann</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Dorothea</i>		MIDDLE <i></i>	LAST <i>Tiemann</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>139-10-6640</i>		17. INFORMANT <i>Son Ralph W. Tieman</i>		ADDRESS <i>715 Glen Drive-West.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Colonic obstruction</i> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 Days.</i>								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Renal Failure, Pneumonia</i>								
19a. DATE OF OPERATION <i>2-15-87</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Colonic Obstruction</i>			20e. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>2/3/87</i> , 19_____, to <i>2/19</i> , 19_____, that (I/we) last saw the deceased alive on <i>2/19</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Norman Goldstein M.D.</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>2-20-87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Norman Goldstein</i>		22e. ADDRESS <i>218 Locust Landing Tower Heights Medical Ctr Westminster, Md 21157</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/23/87</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Presbyterian Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Springfield</i>		COUNTY <i>N.J.</i>	STATE
24. FUNERAL DIRECTOR <i>Eline Funeral Home Reisterstown, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 23 1987</i>						25b. REGISTRAR'S SIGNATURE <i>John L. Anderson, Registrar</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TCI FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then, leave page 2 and carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, etc.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 04948
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR
Mr. Tillson Albert Waesche Jr.			February 22 1987		1 A.M.
3. SEX Male		4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 14 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6301 Candlewicke Court			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager
13a. STATE Maryland		13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6301 Candlewicke Ct. 21784
14. FATHER'S NAME FIRST Tillson Albert Waesche Sr.		MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST Anna R. Huber MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-26-8145	17. INFORMATION Mrs. Felicia Waesche ADDRESS 6301 Candlewicke Court Sykesville Maryland 21784		
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF <i>Acute Myocardial Ischemia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>or INFARCTION</i> MINUTES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ 2 - 4 hrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21e. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 2-6 1984 to 2-22 1987 , that (I) (we) last saw the deceased alive on 2-7 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>B.K. Swisher Jr. M.D.</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 2-23-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Kyle Swisher		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-25-87	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		23d. LOCATION CITY OR TOWN Woodlawn COUNTY Baltimore STATE MD
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc		25a. DATE REC'D BY REGISTRAR FFR 23 1987		25b. REGISTRATION SIGNATURE <i>A. K. Swisher, M.D.</i>	
ADDRESS 8728 Liberty Rd. Randallstown, MD 21133					

1

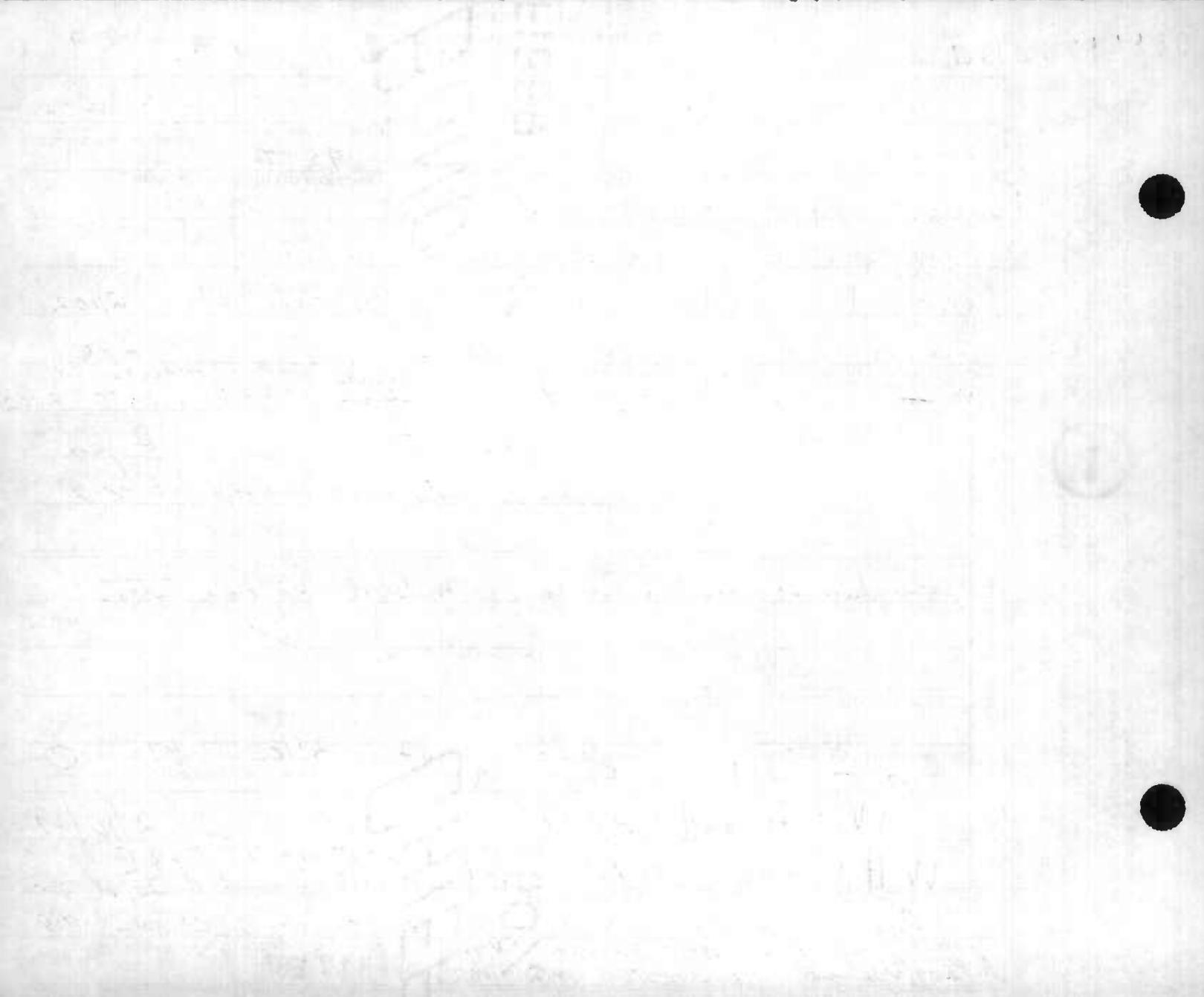
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove call Bellingers. Pages 1 and 2 should be detached for use as the burial permit. Return call Bellingers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked "Yes" to any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 1016A	8709440	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
GEORGIA			V.	Wayne		2	16	87	10:30 A.M.			
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			white	MONTH	DAY	YEAR	95	YRS	IF UNDER 24 HRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Carroll County			United States						Carroll MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
Manchester			Lenview Nursing Home			Housewife			none			
13a STATE			13b COUNTY	13c CITY OR TOWN			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
Md			Carroll	Manchester			First	Middle	Last	First	Middle	Last
George			R	Rupp			Laura			Cooper		MANCHESTER
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO			N/A			L. Jagger			3335 Locust St. 21102			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
			generally demented			5 yrs						
			generalized arterosclerosis			5 yrs						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN DETERMINING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) <input type="checkbox"/> (this hospital) attended the deceased from 10/27, 1982, to 2/16, 1987, that (I) <input type="checkbox"/> (we) last saw the deceased alive on 1/1, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did <input type="checkbox"/> (I/we) did not <input type="checkbox"/> view the body after death.												
22b SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED			
W.H. Fuard MD									2/16/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS			3223 Main St Box E						
W.H. Fuard MD			11 Manchester, Md 21102									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			Feb 18, 1987			WESLEY CHURCH CEM			Hamstead, Carroll MD			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Eckhardt Funeral Chapel						FEB 17 1987			Julia Landon-Randall			
MANCHESTER, MD 21102												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. It should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. DECEASED NAME (TYPE OR PRINT)				MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Mr. Austin W. Widerman						February 17 1987				5:40 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			IF UNDER 24 HRS	
Male		Caucasian		October 19 1894		92		MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		United States						Carroll County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INNOCUITY FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Westminster		Westminster Nursing Home		Farmer/Equip.		Operator #37						
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		MD.		
								2113 Harvest Farm Road		21784		
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMATION		
Walter S. Widerman						Sarah Cavey		218-05-6113		Mrs. Christine Melville 2113 Harvest Farm Road Sykesville Maryland		
18. CAUSE OF DEATH (Enter only one cause per line, Part 1 and Part 2) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Antrum pulmonary arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>G.I. bleeding</u> (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>N/A</u>												
19a. DATE OF OPERATION <u>N/A</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>N/A</u>		21f. LOCATION STREET CITY OR TOWN CITY OR TOWN COUNTY COUNTY STATE STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>1/30</u> , 19 <u>87</u> , to <u>2/17</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>2/15/87</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. DATE SIGNED <u>John W. Middleton</u> <u>2/17/87</u>												
22c. ATTENDING PHYSICIAN <u>John W. Middleton</u>		22d. MEDICAL DIRECTOR <u>John W. Middleton</u>		22e. STAFF PHYSICIAN <u>John W. Middleton</u>		22f. DATE SIGNED <u>John W. Middleton</u> <u>2/17/87</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/21/87		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olive Cemetery		23d. LOCATION CITY OR TOWN Randallstown		COUNTY Baltimore		STATE MD.		
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc 8728 Liberty Road		ADDRESS Randallstown, Maryland 21133		25a. DATE REC'D. BY REGISTRAR FEB 20 1987		25b. REGISTRAR'S SIGNATURE <u>Sue Decker Radke</u>						

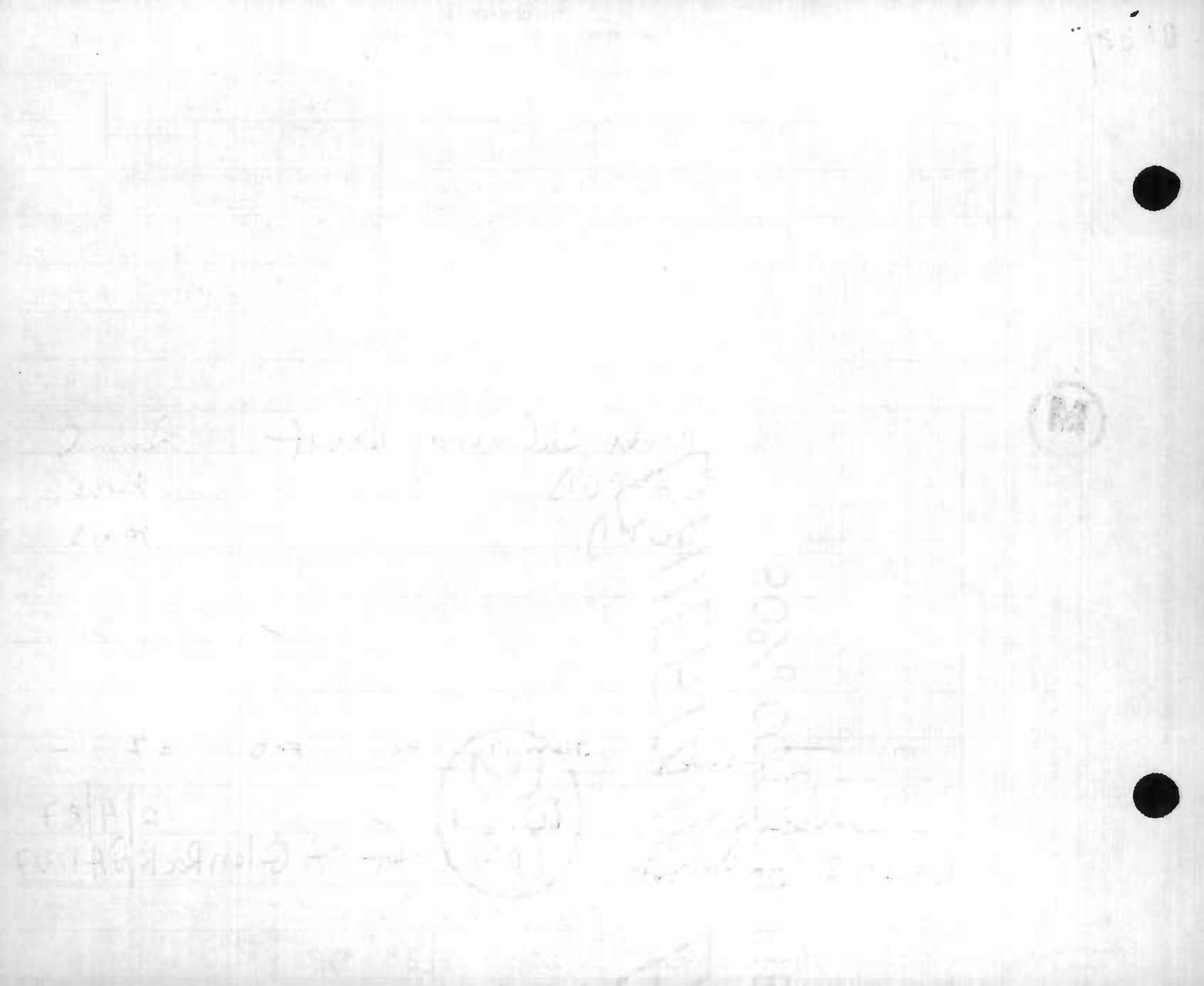
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

completely filled in by the funeral director. Page 3
should be detached for use as the burial/transit permit. Then please remove carbon paper from the back of this page and attach it to the
Funeral Director's slip. This will serve as the Burial/Transit Permit. Then please remove carbon paper from the back of this page and attach it to the
State Dept. of Health and Mental Hygiene prior to burial, cremation, or
exhumation/transplantation.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 04948				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
PAUL D. WILDASIN						February 3, 1987			4:30 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 11, 1915			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County		MD.					
10. CITY OR TOWN OF DEATH Lineboro		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5109 Shaffer Mill Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Worker			12b. KIND OF BUSINESS OR INDUSTRY Food Process ing							
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Lineboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5109 Shaffer Mill Rd. / 21088					
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Peter Wildasin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lorina Lydia Doll												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. -----		17. INFORMANT Dorothy H. Wildasin,		ADDRESS 5109 Shaffer Mill Rd. Lineboro, MD 21088								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteries</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>COPD</u> DUE TO, OR AS A CONSEQUENCE OF Keeps Years												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Dimmed		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) <u>has</u> attended the deceased from <u>Jan 17</u> 19 <u>86</u> , to <u>Feb</u> 19 <u>87</u> , that (I) <u>have</u> last seen the deceased alive on <u>1-28-87</u> 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> view the body after death.												22b. DATE SIGNED 2/4/87		
22c. SIGNATURE <u>DAVID J. Chalker, Jr.</u>		22d. DEGREE DO.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DAVID J. Chalker, Jr.</u>		22f. ADDRESS 60 Water St. Glen Rock, PA 17327												
23a. BURIAL, CREMATION, REMOVAL SPECIFY Cremation		23b. DATE Feb 1987		23c. NAME OF CEMETERY OR CREMATORIAL Yorktowne Caskets, Inc.			23d. LOCATION CITY OR TOWN York,		COUNTY York		STATE PA			
24. FUNERAL DIRECTOR J. J. Hartenstein, New Freedom, PA 17349		24. ADDRESS 24 Second St.			25a. DATE REC'D. BY REGISTRAR FEB 6 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon Radke</u>							



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO. 449

FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)										20. DATE KNOWN OF EST. DEATH MATED		21. HOUR		
			FIRST			MIDDLE			LAST				<input checked="" type="checkbox"/> MONTH DAY YEAR		22. HOUR		
			Laverne			Mitchell			Williams				<input type="checkbox"/> 2/ 11/ 1987		M 11:00 AM		
23. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		24. DATE PRONOUNCED DEAD	
			Male			Black			Aug. 17, 1955 31			YRS.			MONTHS DAYS HOURS MIN		MONTH DAY YEAR
25. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			26. BALTIMORE CITY OR COUNTY OF DEATH		27. HOUR			
			Pennsylvania			U.S.A.			<input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/>			Carroll County		27. HOUR 2/ 11/ 1987 A.M.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
			Taneytown			5752 Taneytown Pike			Provisioning Spc.								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET ADDRESS						
			Maryland			Carroll			Taneytown					5752 Taneytown Pike/21787			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
			FIRST John			MIDDLE William			LAST Williams			<input type="checkbox"/> No		Marguerite Williams		5752 Taneytown Pike Taneytown, MD 21787	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last</u>																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held an			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion											
death resulted from: Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE			TITLE (SPECIFY)			M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED		2/11/87			
EXAMINER'S NAME (TYPE OR PRINT)			Gregory R. Kauffman, M.D.			ADDRESS			111 Penn St.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR			
Burial			02/14/87			St. Francis Xavier			Gettysburg, Adams, Penna.			NAME Skiles Funeral Home		ADDRESS			
														25b. REGISTRAR'S SIGNATURE			
														FEB 17 1987			

1981 10 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from page 3 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "Yes" show any injury, or other traumatic event, that may have contributed to the death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 / 04950								
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
			ERNEST			E				WOODEN		2. 11. 1987					1130 M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE			W.			MONTH 3 DAY 6 YEAR 1886			100			MONTHS YRS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			CARROLL COUNTY									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Westminster			CARROLL County Gen Hospital			CPA & LAWYER			Accounting									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE								
Maryland			Baltimore		Reisterstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13914 Hanover Rd. 21136								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS						
Alexander			Sarah			NO			219-20-7058			Mrs. Ernest E. Wooden, Reisterstown						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. DUE TO, OR AS A CONSEQUENCE OF (b)			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			SUBACUTE BACTERIAL ENDOCARDITIS									1 MONTH						
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
CHRONIC OBSTRUCTIVE PULMONARY DISEASE ARTERIOSCLEROTIC HEART DISEASE																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/22/1987 to 11/11/1987, that (I) (we) lost saw the deceased alive on 11/11/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Ernest Wooden Jr MD</i>										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 2-14-87			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Gilead Cem.			23d. LOCATION CITY OR TOWN Reisterstown			COUNTY Balto	STATE Md.					
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.										25a. DATE REC'D. BY REGISTRAR FEB 13 1987								
										25b. REGISTRAR'S SIGNATURE <i>John S. Johnson, Registrar</i>								

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